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NORTHWEST MEDICINE

January, 1904.

ORIGINAL CONTRIBUTIONS.

INJURIES TO THE LOWER END OF THE HUMERUS IN CHILDHOOD—A STUDY OF THE CONDITIONS EXISTING FIVE YEARS AFTER THE ACCIDENT.

By Charles L. Scudder, M. D.,
BOSTON, MASS.
Surgeon to the Massachusetts General Hospital.

I have become specially interested in certain groups of surgical cases coming into my clinic at the Massachusetts General Hospital. Fractures involving the elbow joints of young children have been so numerous as to command particular attention.

I present here, briefly, the end results in a series of unselected cases. The final observation was made, in each instance, five years after the receipt of the injury. The original diagnosis was made without the assistance of the x-ray. The x-rays here presented demonstrate the existing bony relations. The x-rays were taken through the kindness of Mr. Walter Dodd, of the Massachusetts General Hospital.

The treatment of these cases varied slightly. The child was etherized, the elbow thoroughly examined and the forearm placed in the position which seemed to hold the fracture most completely reduced; either the acutely flexed position or that at a right angle was the position chosen in which to retain the elbow. Massage was used immediately, and at frequent intervals, with primary immobilization, without the removal of the fixation dressing. The elbow was kept immobilized for from four to seven weeks. At the end of that time passive motion was employed and active motion encouraged up to the point of just not hurting the child. Any manifestation of pain during passive motion was immediately respected.

The x-rays in each case are here presented, showing the relative position of the elbow joint bones, and especially the condition of the lower end of the humerus, five full years, in every instance,

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after the fracture. In each case the functional results are perfect. The anatomical results are seen upon inspection of the x-ray.

These cases are reported not to advocate any particular method of treatment to the exclusion of any other methods, but to demonstrate the actual anatomic and functional results following injury to the lower end of the humerus in young children.

Personally, I believe in early massage, long rather than short immobilization (four to seven weeks), and painless passive and active motion after the period of immobilization is completed, in the treatment of fractures of the lower end of the humerus in childhood. Although the anatomic conditions are not perfect in these cases, by any means, the functional results are most satisfactory. With one or two exceptions there is no noticeable deformity upon inspection of the elbow once injured. I am indebted to Dr. Ernest Blodgett, Boston, for assistance in finding the whereabouts of these cases.

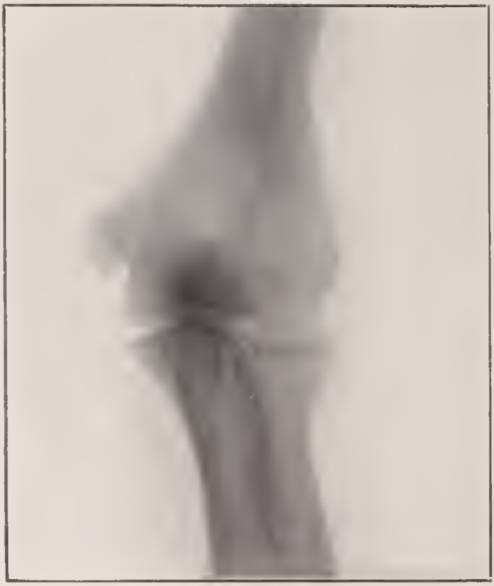

FIGURE 1. X-ray. Antero-posterior view of the uninjured elbow joint of a child, fourteen years old. The forearm is completely extended. This x-ray is shown for comparison with those x-rays that follow.

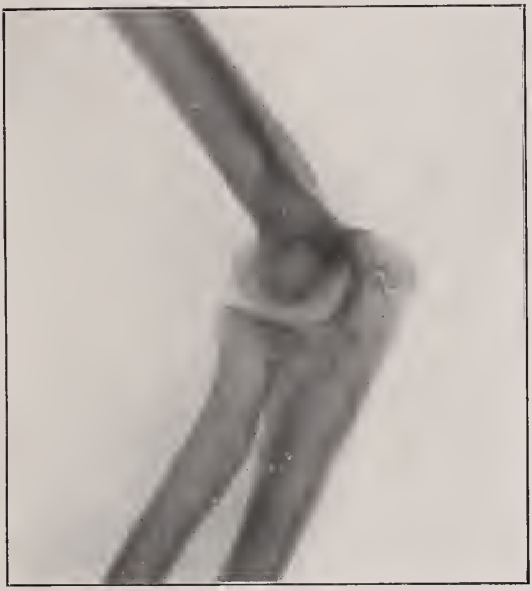

Figure 2. X-ray. Lateral view of the elbow joint seen in Figure 1. The epiphyseal line separating the olecranon process is distinctly shown. The forearm is somewhat flexed.

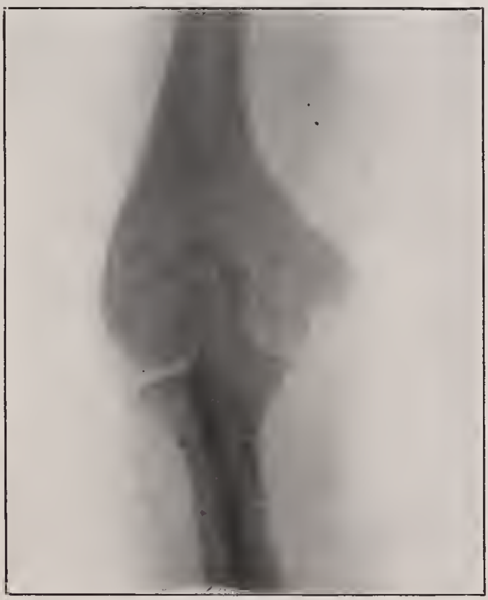

Figure 3. X-ray. Antero-posterior view of the extended elbow of a boy, fourteen years old.

When nine years old, fracture of internal condyle. Five years after the fracture, flexion of the elbow is possible, fifteen degrees from a right angle; extension is limited ten degrees at the extreme point; pronation and supination are normal. The carrying angle is absent. Treatment, acute flexion.

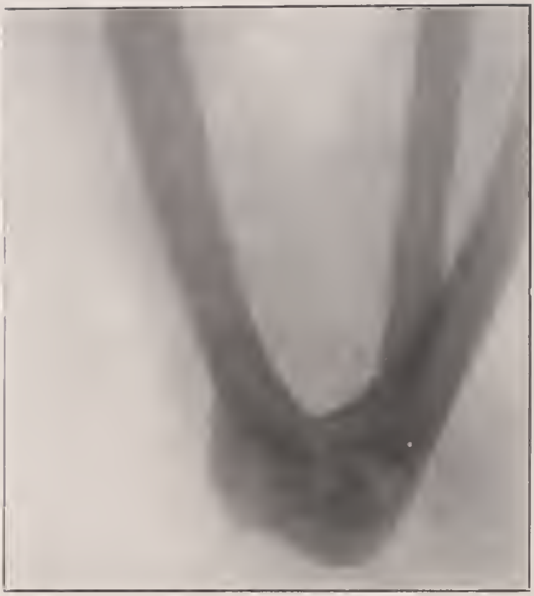

FIGURE 3. Same case as Figure 3. The elbow is flexed.

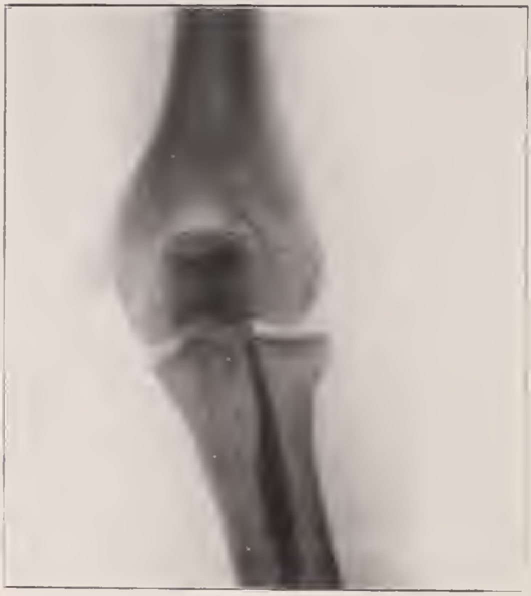

FIGURE 4. X-ray. Antero-posterior view of the extended elbow of a boy, seventeen years old.

When twelve years old fracture of the internal epicondyle and a dislocation of both bones of the forearm backward. Five years after the fracture and dislocation, flexion is possible seventeen degrees from a right angle. Extension is limited eighteen degrees. Pronation is very slightly limited Supination is normal. The carrying angle is slightly less than that of the well arm. Treatment, right angle position.

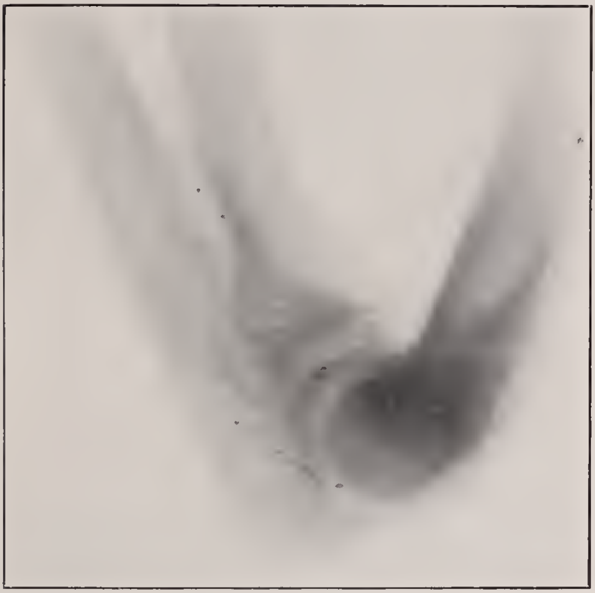

FIGURE 4^1 The same as Figure 4. The elbow is flexed.

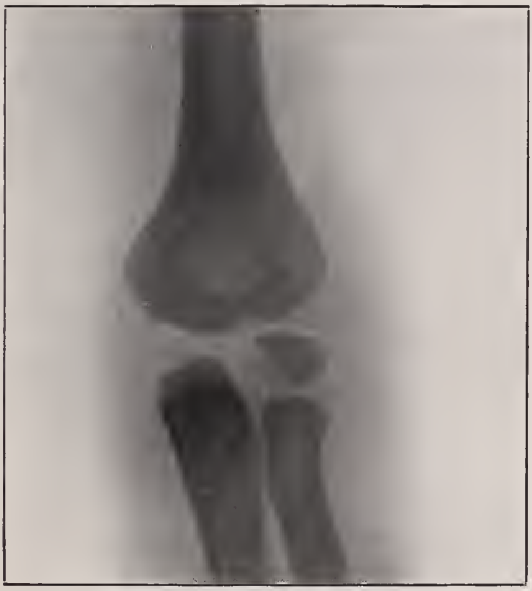

FIGURE 5. X-ray. Antero-posterior view of the extended elbow of a boy, thirteen years old.

When eight years old, fracture of the external condyle. The line of the fracture is seen in the plate. Five years after the fracture, flexion, pronation and supination are normal. Extension is limited seven degrees. The carrying angle is normal. Treatment, right angle position.

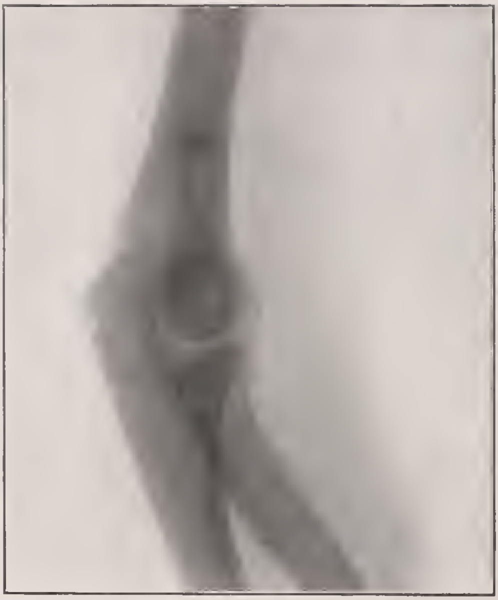

FIGURE 6. X ray. Lateral view of the elbow joint of a boy seventeen years old. The arm is extended.

When twelve years old, fracture of the external condyle. Five years after the injury, flexion, extension, pronation and supination are each normal. The carrying angle is normal. Treatment, acute flexion.

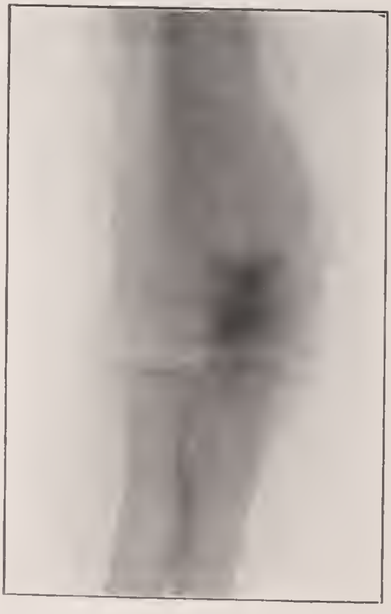

FIGURE 6 X ray. Same case as Figure 6. The arm is extended but the view is an antero-posterior one.

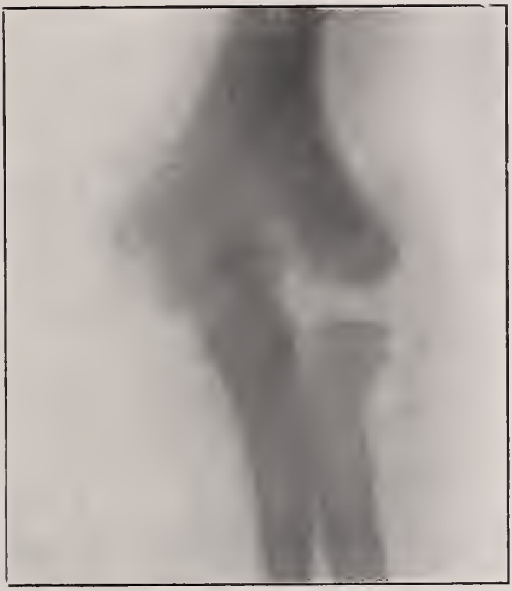

FIGURE 7. X-ray. Antero-posterior view of the elbow joint of a boy, eleven years old. The arm is extended.

When six years old, received a T fracture of the lower end of the humerus into the elbow joint. The widened intercondyloid space is apparent in the x-ray plate. Five years after the fracture, flexion is possible to forty-eight degrees, just beyond a right angle. Extension is limited thirty degrees. Pronation and supination are normal. Treatment by acute flexion.

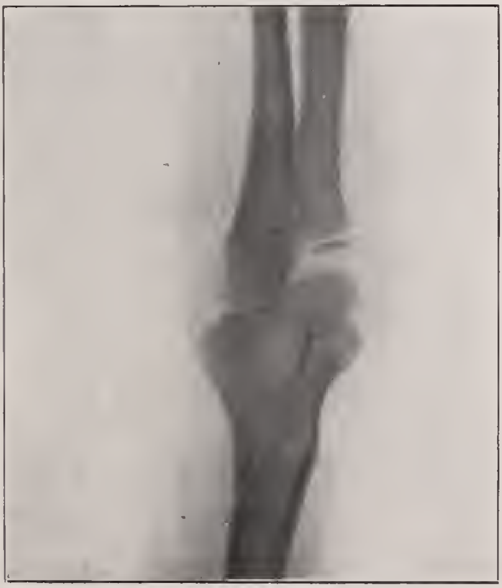

FIGURE 8. X-ray. Antero-posterior view of the elbow joint of a girl of seven years of age. The arm is extended.

When two years old, received a T fracture of the lower end of the humerus into the joint. Five years after the injury, flexion, extension, pronation, supination were all normal. The carrying angle is normal. The treatment was the right angle position.

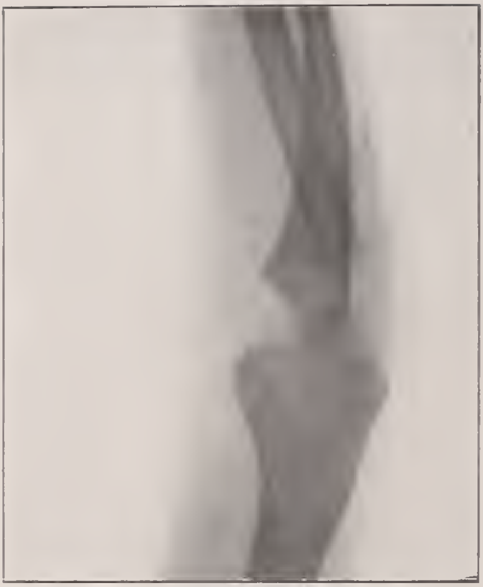

FIGURE 8a. X-ray. A lateral view of same elbow as in Figure 8.

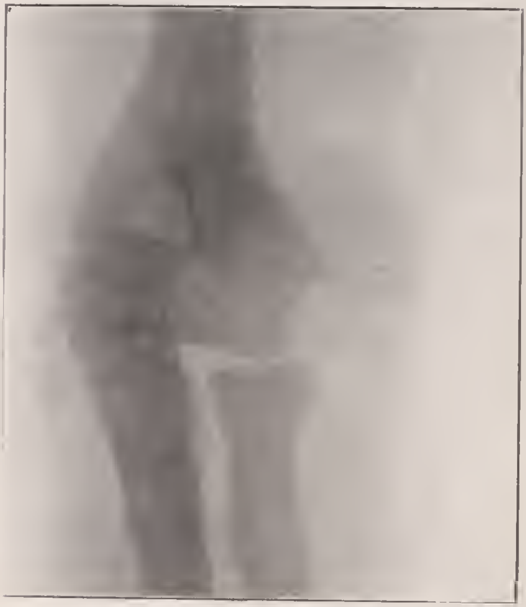

FIGURE 9. X-ray. Antero-posterior view of the extended elbow of a boy sixteen years old.

When eleven years old, fractured the internal condyle. Five years after the fracture flexion is normal, extension is almost normal (see x-ray plate), pronation and supination are normal. Carrying angle, about normal. Treatment at a right angle. A movable internal condyle can be felt.

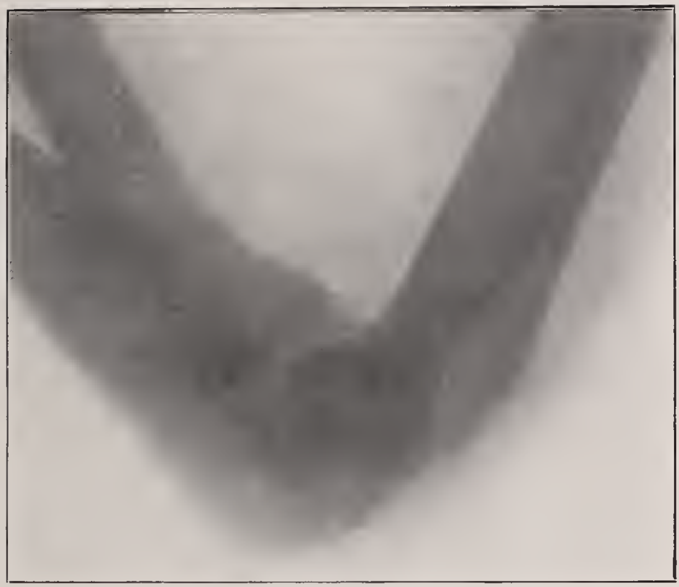

FIGURE 9. Same case as Figure 11. The elbow is flexed.

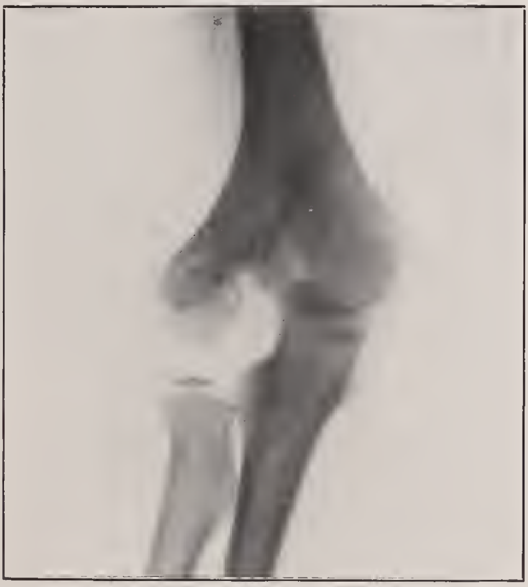

FIGURE 10. X-ray. Antero-posterior view of the extended elbow of a girl seven years old.

When two years old, fractured the external condyle. Five years after the fracture extension, flexion, pronation and supination are normal. Carrying angle is about normal. Treatment at a right angle.

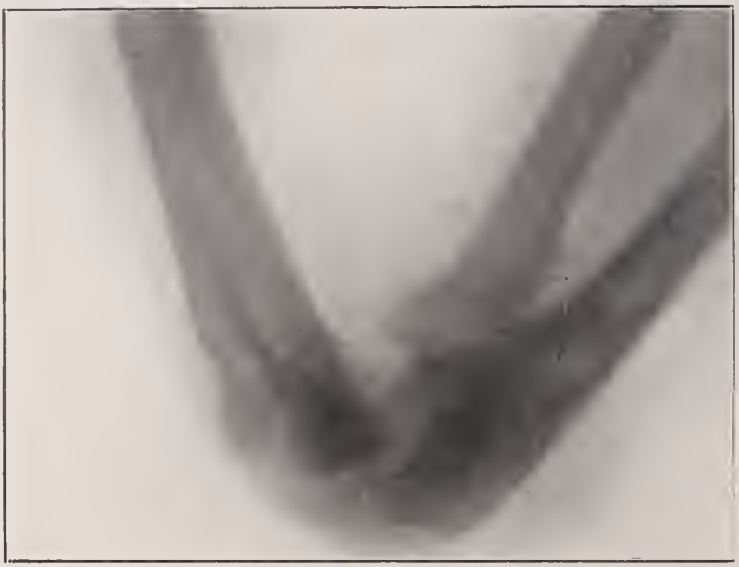

FIGURE 10' Same as case Figure 12. The elbow is flexed.

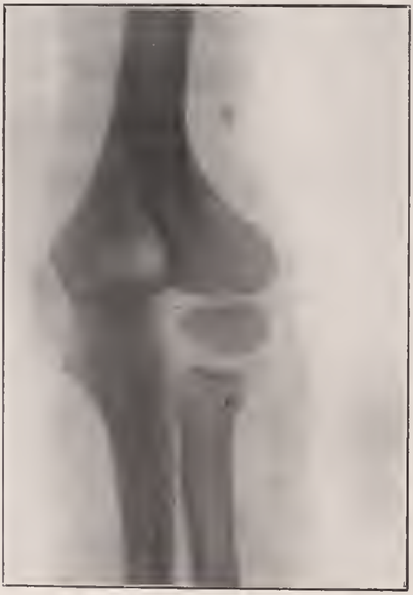

FIGURE 11. X-ray. Antero posterior view of the extended elbow of a boy ten years old.

When five years old, fractured the external condyle. Five years after the fracture, flexion, pronation and supination are normal. Extension is slightly limited. The carrying angle is normal. Treatment in acute flexion.

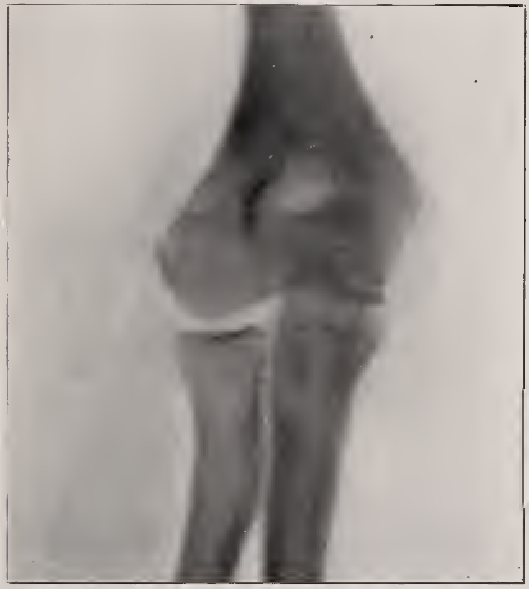

FIGURE 12. X-ray. Antero-posterior view of the extended elbow of a girl twelve years old.

When seven years old, fractured external condyle. Five years after the fracture, flexion and extension are nearly normal. Pronation and supination are normal. The carrying angle is normal. Treatment in acute flexion.

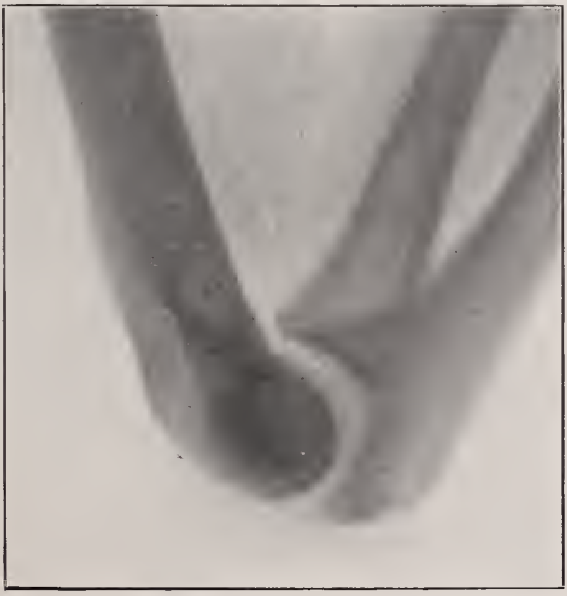

FIGURE 12[1] Same as case in Figure 24. The elbow is flexed.

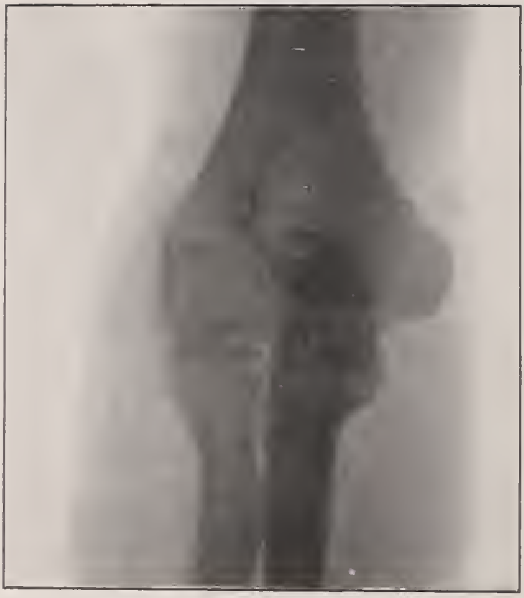

FIGURE 13. X-ray. Antero-posterior view of the extended elbow of a boy, eleven years old.

When about six years old he suffered a compound separation of the lower epiphysis of the humerus. Four and one half to five years after the accident all movements are normal. The carrying angle is slightly less than normal on the injured side.

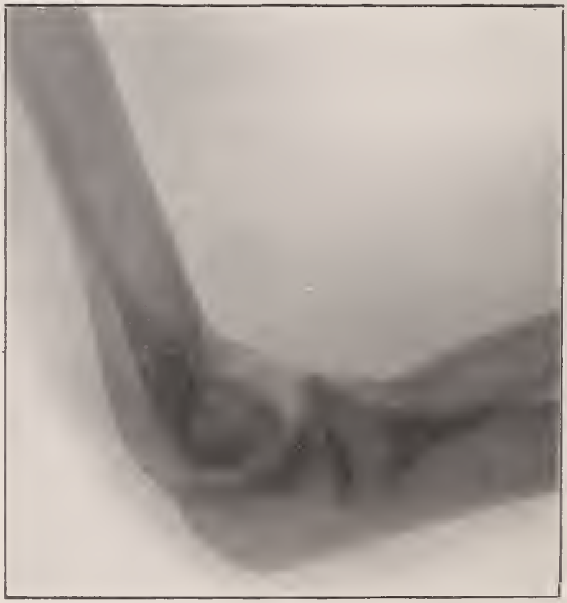

FIGURE 13 Same case as that in Figure 13. The elbow is flexed.

PULMONARY EMBOLISM.*

By R. E. Walker, M. D., L. R. C. P. & S., Edin.
NEW WESTMINSTER, B. C.

Pulmonary embolism, or more properly speaking, occlusion of the pulmonary artery or one of its main branches, is a condition which fortunately does not often present itself to our notice. When it does occur, its onset is so sudden and in the majority of cases, its termination so disastrous, that its very name creates a feeling of dread; sudden death, which is the rule in these cases, occurring in the course of any illness, more particularly in obstetric practice, is most appalling. It carries with it a feeling of horror and no physician, however great his reputation may be, can escape the criticisms which invariably follow, even although the accident is entirely beyond his control. It is only by a thorough familiarity with the cause and by being able to explain how impossible it is to foresee or avert the fatal termination, that he can in some degree hope to modify these adverse criticisms.

The cases, of which I shall briefly give the history, all occurred in obstetric practice, so that in this paper, I shall confine my remarks chiefly to this condition as a consequence or complication of labor, although practically the pathologic condition is the same whether arising after labor or in the course of disease, accident or surgical interference.

Case 1. Mrs. A., aet. 35, a delicate and anemic woman, pregnant for the fourth time, was delivered after a comparatively short labor, on April 18, 1900; the delivery was followed by severe post partum hemorrhage, due to relaxed condition of uterus; this, however, was checked after a few minutes. The patient, anemic before her confinement, was more so now than ever, but gradually recovered without any other symptoms than those due to anemia and was able to sit up for a short time at the end of the second week. On May 12, twenty-four days after the delivery, while in bed, she was suddenly seized with violent dyspnea, precordial distress, oppression and fear of impending death. She was lying on her back, the window of the room was thrown wide open and she complained that she could not get air enough and was breathing rapidly and laboriously. She also complained of pain over heart and left breast; on examination a soft, blowing murmur could be heard over the pulmonary artery; air freely entered both lungs. Temperature was normal; pulse 140, feeble. Absolute rest was enjoined and stimulants and iron administered internally. The dyspnea gradually subsided except when any attempt at movement was made. The patient's general condition steadily improved, although anemia was still very marked, but hope was entertained of her ultimate recovery when, on May 30, eighteen days after the first attack, she was suddenly seized with violent dyspnea and expired within half an hour. The temperature throughout this case was normal and no symptoms of septic infection or of thrombosis of the veins of the extremities existed at any time.

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*Read before the British Columbia Medical Association, Victoria, B. C., October 30 and 31, 1903.

Case 2. Mrs. B., aet. 44, sixth pregnancy, a strong robust woman. Head presented in the occipito-posterior position; she was delivered with forceps after a tedious and difficult labor on November 11, 1902. Septic trouble developed on the third day after delivery, temperature rising to 103.2°; with appropriate treatment this subsided, the temperature was normal and patient convalescent on about the twenty-fifth day after delivery. On December 19, thirty-six days after delivery, she was suddenly seized with intense pain in left breast, with great difficulty of respiration. I saw her within an hour, when she was lying with head elevated, as she could breathe best in this position; marked dyspnea, severe pain in precordial region, pulse 130, respiration 47, temperature 101.4°. On examination, no heart murmur could be heard and air freely entered both lungs. The patient had a persistent dry cough which greatly aggravated the attacks of dyspnea. The dyspnea continued at intervals for about ten days, being always aggravated by movement or coughing. For several days the pulse remained about 120 and respiration between 30 and 40 per minute. On December 25, six days after onset of attack, temperature had fallen to 98.2°, pulse 116, respiration 35, and on January 4, fifteen days after onset, temperature 98.2°, pulse 85, respiration 25. The patient made an uninterrupted recovery and is now in good health. The treatment adopted was free stimulation, whiskey, strychnin and rest. On December 21, two days after onset of attack of dyspnea, patient developed thrombosis of the left femoral veins with all the usual symptoms accompanying it. This subsided as time progressed.

Case 3. This case occurred in the practice of another physician, who is now deceased but, as I was called in when the attack of embolism occurred, I have included it with the others. Mrs. M., aet. 24, primipara, labor normal, slight laceration of perineum. Two or three days after delivery had slight chill and developed tenderness in right side, probably cellulitis; this passed off and she was apparently convalescent and up on twelfth day. While attending to some trivial household duties on the sixteenth day after confinement, she suddenly complained of great pain over heart and difficulty of breathing. She was placed in bed but rapidly became unconscious and died in about fifteen minutes.

These three cases, while presenting a clinical picture similar in their general outline, are symptomatic of a pathologic condition widely different in its etiology. When considering the cause of these attacks we are confronted with the question, is the occlusion due to embolism of the pulmonary artery derived from a thrombosis in some of the systemic veins, or may it be due to primary thrombosis, originating in the pulmonary artery itself? My own opinion, based on what I have observed and from the literature upon the subject, is that, while embolism is the common cause, there are a certain number of cases which cannot be accounted for in any other way than that of primary local thrombosis of the pulmonary artery.

Case 1 must, I think, be considered as a case of primary thrombosis in the pulmonary artery itself. In this case anemia was present in a marked degree, and all writers are agreed that chlorosis is a strong predisposing cause of thrombosis; the absence throughout of any rise in temperature or other symptom of sepsis, the absence of any symptom that would indicate thrombosis of the pelvic veins or those of the lower extremities or elsewhere, from which an embolism could be derived, are strong negative reasons why this should be considered a case of primary thrombosis of the pulmonary artery. Welch, in an exhaustive treatise on this subject of thrombosis and embolism, says: "Although thrombosis is not a common complication of chlorosis, it is sufficiently frequent to indicate a special tendency to its occurrence in this disease."

Playfair strongly advocates the theory that primary thrombosis of the pulmonary artery may occur, and, in support of this view, he points out that the anatomic peculiarity of the pulmonary artery is a predisposing cause; also in puerperal cases that the blood in the latter months of pregnancy is peculiarly rich in fibrin and thus predisposed to the formation of coagula. Welch, in the treatise already referred to, says, "I also believe that primary thrombosis of the pulmonary artery is more frequent than is usually represented in the text-book," and Dr. Newton Pitt says that "thrombosis of the pulmonary artery is far from being rare, possibly occurring more frequently than of any other vein or artery in the body." Many times only, a small branch is occluded without any apparent symptom; it is only when a large-sized vessel is plugged that symptoms occur. Sir Jos. Fayrer is also a strong advocate of the thrombotic theory; he cites sixteen cases of death due to thrombosis, in all of which post mortems were held, and lays particular stress on the depraved condition of blood in malarial and splenic cachexia as a predisposing cause.

Emboli in puerperal cases are generally derived from thrombosis in the veins of the lower extremities or from the veins of the pelvis immediately surrounding the uterus; that thrombi in these veins following labor is practically always of septic origin, is, I think, an established fact, so that, in dealing with such a case of pulmonary embolism, which is not immediately fatal, we have to bear in mind that the resulting infarct is infective and will be followed by a train of symptoms in addition to those of embolism, more or less severe in proportion to the size of the infarct and the virulence of the infection. Case 2 is an example of such a condition; septic thrombosis no doubt existed in the pelvic veins and from it the embolism was derived. The apparent simultaneous appearance of thrombosis in the veins of the left leg, with the pulmonary embolism, was, I think, due to an extension of the septic thrombi from the iliac to the femoral veins.

Playfair, in his system of mid-wifery, cites a somewhat similar case and advances the theory that the thrombosis in the pulmonary artery and the femoral vein both occurred simultaneously and independently, as a result of a peculiar condition of the blood favoring coagulation. I cannot help thinking, however, that sepsis plays the principal part in cases with such a history. Case 3 was also, I believe, a case of embolism; the emboli being derived from the pelvic veins and no doubt due to septic infection.

The time at which obstruction to the pulmonary artery is liable to occur is of some interest. Playfair says that when the accident occurs before the nineteenth day, it is generally thrombosis; when after that time, emboli. Dr. Fordyce, in the Encyclopedia Medica, says that embolism seldom occurs before the end of the second week. I have been able to collect the history of fifteen cases occurring after confinement; of these, seven are reported to be due to thrombosis and occurred one, seven, nine, eleven, twelve and fourteen days after delivery. Eight are reported as due to embolism and occurred three-fourths of an hour, four, four, six, seven, fourteen, twenty-four and seventy days after delivery. Of my own cases, that of thrombosis occurred twenty-four days after delivery, and those of embolism sixteen and thirty-six days after.

A question of some interest, arising out of the cases I have narrated, is the formation of an infarct, a necessary sequence of obstruction of the pulmonary artery or its branches. In both my cases which survived the first attack, no physical signs could be detected in the lungs. Case 1 gave absolutely no evidence either by physical examination or subjective symptoms. With case 2 considerable pain was complained of in the left side posteriorly; cough, already referred to, was a troublesome symptom, but there was no expectoration and only a small amount of frothy mucus. A physical examination gave negative results. The temperature, which run between 100° and 102° for a week or more, might have been caused by the accompanying phlebitis in the vein of the left leg. The collateral circulation in the lungs, through the numerous pulmonary capillaries and with the bronchial and mediastinal arteries, is so abundant that, in occlusion of the medium-sized or smaller vessels, the vitality of the parts is sustained if otherwise healthy. Infarction is most likely to occur in cases complicated by mitral insufficiency or fatty heart, where chronic congestion of the lungs existed. Welch says that the majority of cases of thrombosis and embolism of the pulmonary artery present no evidence of infarct. Newton Pitt places infarct following occlusion of the pulmonary artery as occurring in less than one-third of the cases, but Prof. Anfrecht, in Noethnegal's System of Medicine, says that in his opinion, infarction follows most cases of embolism of medium-sized arteries.

Treatment—I should like to add just a few words as to the treatment. In those cases where the main artery or a large branch has been occluded, the physician seldom has an opportunity of attempting any form of treatment, death generally occurring before he can be summoned, and indeed, if he does arrive before the fatal termination, he can do little to avert it. In many cases, especially puerperal ones, much can be done in the way of prophylaxis. In cases where thrombosis of the veins of the extremities exists, it would seem almost superfluous to emphasize the necessity of rest and the avoidance of massage or friction of the affected limb; should thrombosis of the pelvic veins be suspected in the course of an obstetric or gynecologic case, prolonged rest in bed should be enforced. Should chlorosis complicate the case, as it generally does, the free administration of iron is indicated. Cases which must always give the medical man considerable anxiety are those in which an extreme degree of chlorosis exists and which are complicated by the puerperal condition or by recent operation. I think in such cases, following the puerperal period, that rest in bed, much beyond the time ordinarily prescribed, should be insisted upon. When an attack has occurred and the patient survives the immediate onset, absolute rest in bed in the recumbent or semi-recumbent position is essentially necessary; often the slightest movement, such as raising the hand to the mouth, aggravates the dyspnea; free stimulation with whisky and strychnin, the latter preferably by hypodermic injection, and liquid diet are the principal indications. Should much restlessness and pain exist, morphin (gr. ¼) is a safe and reliable remedy.

DISCUSSION.

The discussion was opened by Dr. Fraser, of Victoria, who complimented the essayist on his excellent paper, and said that he could speak only from theoretical knowledge as his own experience with the disease had been very limited.

Dr. Willis, of Seattle, spoke of the necessity for exercising the greatest care in the way of asepsis in all cases of obstetrics and advocated the use of rubber gloves in every case.

Dr. Ralston, Jr., of Victoria, related an interesting case following typhoid fever complicated with thrombus of the femoral vein, which occurred in his practice, while with the troops in South Africa.

Dr. Shannon, of Seattle, expressed his high appreciation of the paper and thought that it would stimulate a more careful study of this class of diseases.

Dr. Durand, of Everett, related a case which occurred in his practice a few weeks before, which had puzzled him very much at the time, but that, in the light thrown upon the subject by the paper and the discussions, he now believed to have been a pulmonary embolism.

The paper was also discussed by Drs. Gibbs, Corbett, Hall, Jones, and Fagan, of Victoria.

Dr. Walker, in closing, said he was glad that the paper had brought out such a thorough discussion, and he thanked the members present for their interest in it.

SEPTIC SYNOVITIS.*

By ALFRED RAYMOND, M. D.,

SEATTLE, WASH.

During the last few years I have had under my care quite a number of cases of septic synovitis, both acute and sub-acute, and as very little is found in the text books on the subject, some of them merely mentioning the fact of its occurrence, I have tried to embody my observations regarding diagnosis and treatment in this brief paper, with reports of some of the cases as illustrations.

When a patient is suffering from one or more swollen joints, which are hot and painful, accompanied with considerable temperature, it is usual to consider and treat the case as one of rheumatic fever. But if one observe closely he will see that they are not accompanied by sweating, which I believe is always a symptom of rheumatic fever. There are two points nearly always present in sepsis, which do not occur in rheumatic fever, namely, the dry, harsh skin and a restless, distressed, unhappy condition which exists in the patient. There is a large group of cases which resemble acute rheumatic fever and are not amenable to anti-rheumatic drugs, but are due to some septic cause. Probably some day they will be placed in their proper category.

GONORRHEAL SYNOVITIS—The first form of septic synovitis I wish to mention is gonorrheal synovitis. I believe the term gonorrheal rheumatism should be abandoned, as we now know beyond a doubt that it is not rheumatism at all, but a septic condition of the synovial membrane, due to the gonococcus or its toxins. I have always understood that an inflammation of a single joint, or a monarticular inflammation coming on in a young individual, is suggestive of gonorrhea. The onset is sudden and usually not very painful, is accompanied by some temperature and rapid atrophy of the muscles governing the joint, which is a prominent and never failing sign. If, after rest, strapping and the usual remedies have been administered, as salicylates, iodides, mercury, etc., the joint shall remain distended, no further time should be wasted, but it should be opened, washed out with a sterile, normal, saline solution and the wound immediately closed. The limb should be kept quiet until healed, which will probably take about two weeks, when the patient may be advised to use it and have it properly massaged. I am utterly opposed to the use of any antiseptic other than the saline solution, for the washing out of the joint, because the synovial membrane has been sufficiently irritated by the germs and their toxins, and a chemical solution would further act as an irritant and lessen the protective power of the membrane. No one now would think of washing out the peritoneal cavity with bichloride of mercury or carbolic acid, and since the synovial membrane and peritoneum have many points in common, these should not be used in washing out a joint. We know strong antiseptic solutions will kill germs, but they will also injure the protecting power of the membrane, which would then have a double enemy to contend with.

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*Read before the King County Medical Society, Seattle, May 4, 1903.

Eighteen months ago I was called to see a young married man who was suffering from inflammation of several points. On examination I found both knees, one shoulder and one elbow swollen, painful, tender and red. Temperature of 103°, pulse corresponding. There was no cardiac manifestation of disease. I told him it was a severe case of acute rheumatic fever. After writing a prescription for soda salicylate and an alkali I started to leave the house when his wife followed me to the door and asked me if her husband's trouble might not be due to gonorrhea. That rather startled me. I went back and found he was suffering from gonorrhea, and of course was forced to change my diagnosis of the case. I sent him to the hospital, the next day opened and washed out both knees with saline solution, closed the wound and in two weeks advised him to use the limbs and directed how to massage them. The shoulder and elbow were several months in recovering.

Synovitis Due to La Grippe and Tonsilitis—Two years ago I saw a case of synovitis of the wrist, occurring during an attack of la grippe and tonsilitis, which if I had recognized earlier I would have subjected to the same treatment. I believed for a long time it was tuberculous, but finally, after five or six months, it got well with considerable stiffening of the joint as a result.

Pneumococcus Synovitis—Five years ago I was called to see a young man, living in a shack on the tide lands south of the city, on account of great suffering in the right knee joint. On examination I believed it was a beginning attack of acute rheumatic fever. The joint was painful, hot and tender, and considerably swollen. The temperature was over 104°. I prescribed soda salicylate and an alkali. Next day I found him with pneumonia. I sent him to the hospital; the pneumonia ran the usual course, and on the ninth day he had the pulmonary physical signs of a crisis, but the temperature did not drop to normal, varying from 100° to 102½°. The knee remained painful and swollen. This continued for some days, when I opened it and washed it out with saline solution, drained it for several days; when the drain was removed and the wound allowed to heal. In about four weeks I permitted him to use the limb and have it properly massaged.

This is the only case of pneumococcus infection of the keen joint I have ever seen.

The discovery that the pneumococcus has the power of producing acute inflammation of the joints was of highest importance, not only of itself, but on account of the impetus it gave to the study of infective arthritis. In an article in the *British Medical Journal* by Dr. Cave, when he published his paper on pneumococcus arthritis, he furnished a table of thirty-one cases. He said in all these, arthritis was developed in from two to fifteen days after the onset of pneumonia. In only two did the arthritis precede the pneumonia. In my case it preceded or was coincident with the onset. In the thirty-one cases, twenty-five occurred in males. The disease attacked all the joints in turn. In some cases only one joint was affected. In others, several were involved. Suppuration occurred in twenty-seven cases, and twenty-three out of the thirty-one died, which shows it to be indicative of great mortality, and a very serious complication.

PYEMIC SYNOVITIS—I have had three cases of pyemic synovitis. In these their urgency is suggestive of quick action. I opened the joints, drained and irrigated them every day with saline solution. Here a joint is distended with pus, but, because of its rapid formation and early recognition, the joint is freely opened and drained before the synovial membrane is disorganized, with the result that the membrane reasserts itself and a good joint is preserved for the patient.

A case treated two years ago I wish to describe on account of its being very unique, and as I have never seen any report or literature showing the same facts, I think it is worth recording. A miner in the Cascades nicked his knee cap with an axe. In two or three days it began to swell and become painful. It was during the winter, and to reach the city for treatment he was obliged to walk many miles from Monte Cristo down to the Great Northern Railroad, in snow many feet deep. It took him three days to get to Seattle. When I saw him his knee was three times the normal size, hot and tender; temperature of 105°. I sent him to the hospital, opened the joint and washed it out with saline solution. The joint was completely distended with a fluid as green as grass, due to an infection of the bacillus pyocyaneus. The amount of discharge that came from that joint was almost incredible. There were pints of pus daily, the color of paris green, which continued for nearly eight weeks, when it suddenly stopped in forty-eight hours, and the wound rapidly healed. He returned to the mine and went to work. I saw him the other day with as useful a knee as ever.

In cases of injury followed with increasing temperature, great distension, local pain and general distress, no time should be lost. The joint should be opened, and, if necessary, be drained. In this manner the aseptic fluid has been gotten rid of before damage has occurred to the membrane, and thereby the movements of the joint preserved. When once the cartilages have been eroded, a stiff joint is the natural result. There are other infectious diseases in which the joints are affected by their specific germs, but I have had no experience with them. Keene, in his work, "Surgical Complications of Typhoid Fever," says the typhoid bacillus causes a form of septic arthritis. I have never seen a case.

SYNOVITIS DUE TO GLANDERS.—I rememmer a case under Dr. Osler, when I was a senior student, in which all the joints suppurated, as part of a general pyemia. The man was a hostler. One night he got drunk and slept in the manger with a horse suffering with glanders, from which he contracted the disease. In those days we did not know the true cause of glanders, which at present is known to be a specific organism.

In looking over text books we find some mention the fact that scarlet fever and erysipelas can cause septic joint disease, but I have never seen a case of either.

THE STUDY OF PRACTICAL ANATOMY WITH THAT OF MEDICINE AND SURGERY.*

By Joseph Gibbs, M. D.

VICTORIA, B. C.

The object of my few remarks is to bring before this association, representative as it is of the progress of medicine in the Dominion, the subject of the advisability of the combined study of practical anatomy with that of medicine and surgery.

The progress of surgery within the last decade has been such that, unless we have the advantage of the practical departments of a medical college, it is with great difficulty we can keep abreast with developments, and especially is this the case with those who are located in isolated districts, who keenly feel the necessity of frequent review of dissection. The importance of a thorough knowledge of anatomy is being more and more emphasized.

It is no doubt the lack of exact anatomical knowledge, which is the cause of so much timidity among general practitioners with regard to simple life-saving surgical operations on abdominal viscera, which operations can and should be done by any medical practitioner. Then again, with regard to diagnosis, which after all, is our rock and foundation, it is next to impossible to appreciate diseased structure without having first and foremost a practical and exact knowledge of normal anatomic relations. A knowledge of normal structure and function is essential, combined with a practical knowledge of pathologic conditions, before it is possible to analyze the symptoms of disease and rationally apply the principles of therapeutical remedies, or surgical technique. After all, it is principles we want, and these can be evolved only by the practical, individual study of essentials, viz., anatomy physiology and pathology.

The spaces in our journals are too much taken up with reports of cases and surgical technique, which at the best are of very little real value. Any tyro can easily learn surgical technique, and as to new operations, that is a matter of individual experience. Each operator has, or should have, his own method of operating, and method is a matter of our personal individuality.

There appears to be a prejudice existing in the minds of the profession with regard to the practical study of anatomy while engaged in actual practice. This important subject has not, so far as I have learned, been discussed in a meeting of any medical association in either Canada or the United States. The physician, general practitioner, and even surgeons, will unblushingly admit that his knowledge of anatomy is very unsatisfactory. During my medical course the final students seemed to glory in the fact that they had forgotten their anatomy, and during a six months' course of post graduate work in Chicago, as resident surgeon in the Post Graduate Hospital and in the Woman's Hospital, I had ample opportunity of observing the great lack of knowledge of the structures and functions of the human body, as displayed by the many practitioners attending the clinics. Several well known teachers have told me that their greatest difficulty in the teaching of practising physicians and surgeons is due to the deplorable lack of knowledge of anatomy.

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*Read before the Dominion Medical Association, London, Ont., Aug. 27, 1903.

The anatomy as learned by the medical student during his course is not appreciated, and that knowledge is nicely summed up by Sir Frederick Treves, in the preface to his excellent work on surgical applied anatomy, where he says, "The student of human applied anatomy has often a nebulous notion that what he is learning will sometime prove of service to him, and may be conscious also that the study is a valuable, if somewhat unexciting, mental exercise. Beyond these impressions he must regard his efforts as concerned merely in the accumulation of a number of hard, unassimilable facts." This statement is undoubtedly only too true and coming from such an authority, reinforced by our individual experience, does it not seem that it is our duty to encourage in every way the practical study of this, the first principle of our profession?

But for the question at issue—Can the practical study of anatomy be combined with the practice of medicine and surgery? It appears that the only barrier to a decided answer in the affirmative is the fact of their being a wide-spread impression throughout the profession, of the great danger of infection. Is this impression the result of practical experience, or can its origin be traced to some previous vague association of the dissecting room, offending our esthetic senses? In my own experience, during the past eight months, during which time I have been combining practical dissections with my usual routine of practice, I have had but one unfortunate experience, and in this particular case I assisted and did not have my hands in the abdomen. Outside of this, I have had my hands in forty to fifty abdomens, have attended in the neighborhood of twenty-five confinements, and have done quite a little minor office surgery with no infection. Dr. Byron Robinson writes me that during the past twenty years he has made over one hundred dissections of the human body, a great many dissections of animals and upwards of six hundred post mortems; that he has also done a large continuous gynecologic, operative practice, without a single instance of infection traceable to his dissections.

Sir Frederick Treves is, I understand, an ardent advocate of the combined practice of practical dissections with that of the practice of surgery and medicine. This is also the case throughout the German clinics.

The twenty years' experience of Byron Robinson should surely be seriously considered. We are undoubtedly too loathe to give up our deep-rooted opinions, even though they are in the very great majority of instances not based upon practical experience Experience is the true teacher, but in this instance I think it is safe to say the profession has allowed itself to be governed by prejudice which appears to be groundless. On the other hand, if infection is a real and not imaginary danger, is it not high time that we should set about the task of evolving some means of making our dissecting material aseptic?

CLINICAL REPORTS.

REPORT OF TWO CASES OF EXTENSIVE FRACTURES OF THE SKULL WITH GREAT LOSS OF BONY SUBSTANCE WITHOUT APPARENTLY MUCH DISCOMFORT TO THE PATIENTS.

By George M. Horton, M. D.
SEATTLE, WASH.

Case 1. Albert P., age 40, Russian Finn. Was struck on the head with a bottle while under the influence of liquor; does not remember anything that happened after that for three days, during which time he was unattended by any doctor. When he regained consciousness he found his head and face covered with blood and complained of the former being very sore; he did not think at this time he was hurt very badly. Had been bleeding from the nose and left ear, that being the side on which he was struck. When he awoke he complained of being hungry and after getting something to eat started out to the camp to resume his work; when he arrived there the foreman noticed that he was acting rather strangely and instructed him to return to town and consult a doctor. He was unable to articulate plainly at this time and could not hear in the left ear, but hearing was perfectly distinct in right ear.

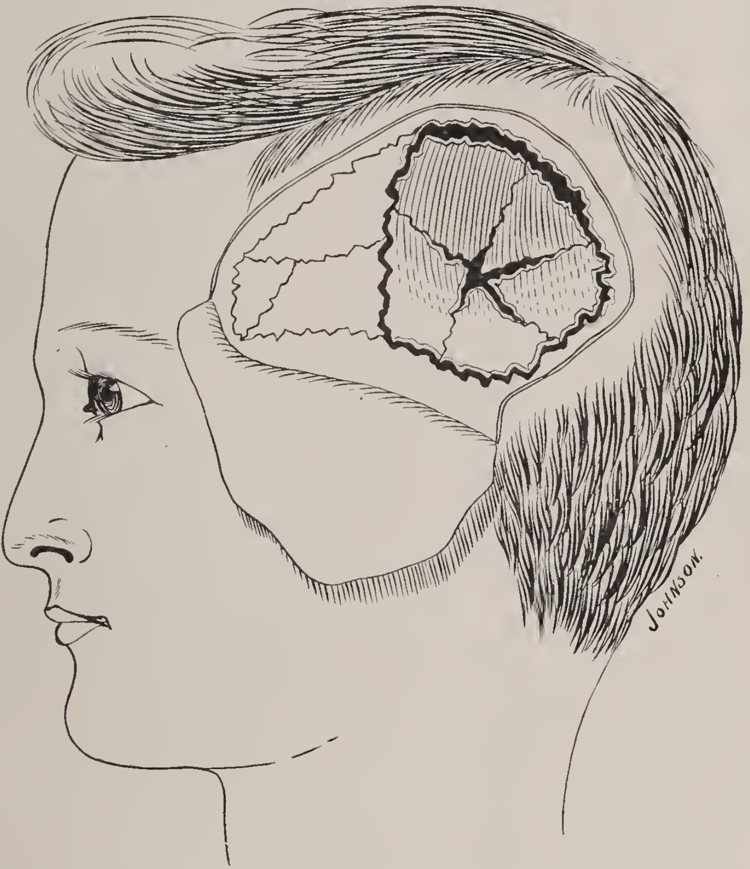
He was in much pain at this time and unable to sleep; he could not walk after arriving at the camp, from the pain in his legs. He was examined by a doctor who informed him that it would be necessary for him to undergo an operation in order to be relieved, which advice he did not take at first, waiting one month and a half before coming to Seattle, suffering much pain during this time. When he consulted me at my office, I found, upon examination, a marked depression in the skull over the left ear about the size of the top of a tea cup; there was no ecchymosis over the wound at this time, but he was still complaining of great pain in the head. I sent him to the hospital and operated on May 8, 1903, making an incision from just in front of the left ear extending upwards and backwards to the parietal eminence and downward to the mastiod portion of the temporal bone.

On raising the scalp I found a fracture involving the parietal, temporal and occipital bones. It was depressed about its edges from one-eighth to one-fourth of an inch, and in the center of the fracture to the depth of five-eighths of an inch. There were eight separate pieces of bone, all of which were removed, as it was impossible to raise these fragments and leave them in place, they being fractured so badly. There was quite a large clot in the center of the fracture, underneath the dura mater, which was removed, all sharp pieces of bone were removed from the surrounding edge, and the scalp brought back over the wound, no plate being used.

The patient made an uninterrupted recovery; has had no pain since the operation; mind is perfectly clear and was able to hear on July 14, 1903, in the left ear, a watch held eighteen inches from the head;

has resumed his occupation as woodsman and says that he feels just as good as he ever did in his life.

I am indebted to Dr. S. S. Johnson for the accompanying cut, which was sketched at the time of the operation.



Case 1. This illustration shows very clearly the location of the fracture and is drawn to scale of about one half the natural size.
The fracture in the live subject from the point in front of the ear to the extreme point back of the ear was five inches; its length from point back of ear upward and backward measured two and a half inches; from the highest point above the ear downward and backward was two inches.

Case 2. Fred E., age 41, German, married, bartender. Patient a large man, dark complexion. On August 9, 1902, at 6 o'clock a. m., he was struck on the head with a king bolt from a heavy wagon. I was called and found the man in a semi-unconscious condition; on making a superficial examination of the head, I found there was an extensive fracture of the posterior part of the skull, the wound in the scalp having been closed by a doctor before I arrived. I ordered the patient removed to the hospital and upon being anesthetized the following conditions were found:

On examining the contusion it felt loose as cracked ice would feel in an ice cap, due to the small fragments of loose bone under the scalp, in the blood clot. The wound in the scalp was very extensive and looked as if made with a knife, as the edges were very clean cut. On taking out the stitches there was found a very large clot of blood under the scalp which was removed and showed the numerous fragments of bone, some being imbeded in the brain tissue, causing extensive laceration. There was considerable loss of brain substance. Twenty-four pieces of the skull were removed; there was a great amount of hemorrhage which was controlled by pressure. The wound was closed, with drainage, and the patient put to bed; he remained unconscious for three days and upon regaining consciousness was found to be totally blind, which condition remained for ten days, when the sight gradually returned. The patient improved rapidly and left the hospital in four weeks.

Examination Jan. 7, 1904, revealed the parts completely healed and the patient has entirely recovered, except a little dizziness at times. The sight in the right eye has never been quite normal; he has slight dizziness on looking up suddenly. The seat of fracture is not entirely covered with bone, there being a space of ½x¾ of an inch with no bone covering.

NORTHWEST MEDICINE

CLARENCE A. SMITH, A. B., M. D., Editor in Chief.
JAMES B. EAGLESON, Managing Editor.

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OUR NEW YEAR'S GREETING.

Having successfully passed through the trials and tribulations of the first year of existence, we feel that the period of swaddling clothes has been forever left behind and that, with one leap, we have reached full grown manhood. While all of the ambitions and hopes of a year ago have not been realized, we have approached sufficiently close to our ideal to fill us with satisfaction and inspire the expectation of more nearly attaining it in the future. Although a few croakers, at the outset, questioned the necessity and usefulness of another medical journal, the cordial reception given us by the profession of the Northwest has proven that we really fill a long-felt want. We believe NORTHWEST MEDICINE, during its first year of existence, has appeared of a quality and character such as to justify a feeling of pride and self-congratulation on our part. As stated in our salutatory to the medical public, we aimed to confine our reading pages exclusively to medical articles and communications of a strictly ethical nature and of as great intrinsic value as could be obtained. The indications of approval as to this course, which have reached us from various sources, have been most gratifying. We take this occasion to express our appreciation. to our contributors and editorial collaborators, of the value of their services and assistance during the period of development.

While the early years of a medical journal must necessarily present perplexing financial problems. we have prospered beyond our expectations, having a goodly number of physicians personally interested in our welfare, whose paid subscriptions gave us a start. Otherwise we have been almost entirely self-supporting and will be so, in fact, very soon. For this we are largely indebted to our advertisers who have thus far patronized us generously. We wish to call the attention of our readers to the fact that we accept only advertisements of ethical character. This principle has caused us to return cash, sent with what we considered objectionable advertising matter. We believe the following of this practice will be appreciated by both our readers and advertisers.

For the future we shall endeavor, as in the past, to present a clean journal, devoted to the interests of the profession as a whole, not published for the benefit of individuals nor of a single locality. We would solicit an interest in this journal, on the part of all physicians reached by our circulation. We have not yet reached perfection in medical journalism, and we are open to suggestions from our friends. We shall take pleasure in publishing communications on matters of medical interest, whether from individuals or organizations. We wish, once more, to urge upon the County Medical Societies, the value to them, as well as interest to others, of the regular publication of the proceedings of their meetings. We will gladly publish such as are received by us, and trust this custom may be adopted by all of the societies.

No journal can ever be satisfied with its subscription list. In the nature of things more subscribers are always needed. We believe we can be of sufficient service to the physicians of the Northwest to warrant our reception on the part of every one in this region. We shall not intrude when not desired, but we do now, as we shall continue to do hereafter, solicit a subscription from every practitioner in the Northwest, into whose office we do not now regularly enter. We wish them all a prosperous new year, attended by health and happiness.

THE STATE ASSOCIATION AND COUNTY SOCIETIES.

One of the leading, if not most important function of a state medical association should be the uniting of the profession of the state into a powerful, harmonious body. The efforts of its officers and expenditure of its funds should be directed first to this end, rather than to the pleasure and entertainment of its members at periodical assemblies.

According to the generally accepted plan of recent reorganization, its own existence and strength depends wholly on the prosperity of its component county societies. Therefore, to attain the desired object, these smaller bodies should be developed and encouraged by the parent organization. It is patent to even a casual observer that nothing is accomplished to this end merely by the annual meeting of the State Association. Among some of the States of the Northwest beyond collecting its annual dues from the county society, the Association has no relation with it whatsoever. If the example of other similarly organized bodies were followed, closer relationship would be established by personal visitations from a representative of the Association to each county society.

The scheme of a Board of Councilors, each of whom shall have supervision over the societies of a certain district, is undoubtedly useful in the populous Eastern States, where each county has a thriving society. But in the sparsely settled States of the Northwest, with comparatively few county societies, the one person best suited for personal visitation is the President of the State Association, who stands as the most prominent and influential member of the organization. It should be established that he be required, during his term of office, to visit each county society of the State. For this purpose a schedule should be prepared so that the date of his visit will be known and preparations made for it. With many of the smaller societies this would be the event of the year; with all it could be made an occasion for local growth and a stimulus to activity, obtained in no other manner. Through such visits the societies could be kept in touch with each other and be brought more closely in contact with the State Association.

The expenses thus incurred should be paid from the treasury of the Association. The custom has prevailed for several years, in the States of the Northwest, to expend a large proportion of the Association's funds for the entertainment of one or more men of prominence from the East, at the annual meeting. In the case of Washington, this has practically consumed the whole income. While this has always been a source of interest and pleasure to the members in attendance, it has been of no benefit to the profession of the State at large. It has been demonstrated that successful and profitable meetings can be held with material furnished by the profession of each State and its neighbors. Therefore, we advocate abandoning this custom, at least for a certain period, and the employment of the resources of the State Association for internal development, according to the plan herein suggested. At the next meeting of the Washington Association we trust that a resolution will be presented, directing the President to pay such an annual visit to each county society in the State.

MEDICAL NOTES.

Annual Banquet of King County Medical Society.—The banquet has become a prominent feature of the life of the King County Society. This year it was held at the beautiful hotel, The Washington, on the evening of January 4, sixty men being present. It was thus the largest in point of attendance, the most interesting as to the number and character of the toasts, and in the spirit of good fellowship that the society has yet experienced. The setting of the tables, menu presented and general surroundings were most attractive.

The guests were Drs. Yocum and Burns, of Tacoma; Cox and Durand, of Everett; Wheeler, of the U. S. Navy. It was a source of regret that several, expected from other cities, were unable to be present. One pleasant and profitable feature of such an affair is the bringing together, in social relations, of physicians from adjacent cities who, otherwise, are rarely thrown into personal contact.

After a thorough discussion of the satisfying menu, the retiring President, Dr. Sweeney, proposed a series of toasts in a felicitous and happy manner, the responses to which covered a wide range of subjects pertaining to the interests of local medical matters, those of the state and the profession in general.

Dr. F. H. Coe, in reply to THE STATE MEDICAL EXAMINING BOARD, referred especially to the agitation concerning reciprocity with the boards of other states and the criticisms directed to this, in consequence of its absence. He said that, in view of the varying standards of different state boards, it is difficult to establish rules for this object. Furthermore, for our own protection we are better off without reciprocity. Well qualified practitioners have no fear of the examination nor difficulty in passing it. Others are not wanted, and the examination discloses them.

Dr. Burns spoke, in his usual happy and humorous vein, on FRATERNITY AND GOOD-FELLOWSHIP IN MEDICINE. While we may often appear hostile to one another in the strife and competition of practice, in reality we display a marked spirit of fraternity and good will. Physicians have always been distinguished for standing by one another in time of trouble and illness. May they ever continue this custom.

In response to NORTHWEST MEDICINE, Dr. C. A. Smith briefly described the experiences of the journal during the past year and mentioned the favorable prospects for the future which promised to establish it on a permanent basis.

Dr. O. A. Loe described the SOCIAL CONDITIONS IN OUR PROFESSION and spoke in favor of anything that will promote such conditions.

In response to LODGE PRACTICE, Dr. W. A. Shannon deprecated the existence of circumstances that tend to belittle the services of the physician, as is true in this sort of practice. The necessity of securing a start compels men to accept this contract work and no escape from the conditions is apparent. He urged the individual to maintain his own professional dignity and thus reflect, in a favorable manner, on the profession.

Dr. S. J. Holmes gave a unique and amusing response to THE DEFINITION OF A QUACK, presenting dictionary authority for discovering anatomic similarity between this medical genus and a goose, ass and liar.

Replying to SOME NEEDS OF OUR SOCIETY, Dr. Alfred Raymond expressed the hope that it might some day possess a home of its own, an Academy of Medicine, with assembly, library and laboratory rooms. He outlined a possible scheme for producing the necessary funds for such an institution.

Dr. Wheeler responded to THE ARMY AND NAVY in a few well chosen words.

In response to THE LADIES, Dr. S. A. Owens demonstrated the devotion of mankind to the gentler sex and proved man's dependence on woman from the infancy of the race to the present day.

The following delivered brief speeches or related anecdotes of a more or less medical character: Drs. Sharples, Read, Churchill, Eagleson, Cox, Peterkin, Durand, De Beck and Perry.

The society dissolved at an early hour of the morning, in a pleasant frame of mind.

The Winter Session of the Washington Examining Board.—The examination was held at Tacoma, January 5, 6 and 7.

It was thought best, on account of the hurried work required for a two days' examination, that the time should henceforth be lengthened to three days.

It was decided that the revision committee be continued. Its duties are to take the fifteen questions submitted by each examiner, and from these select ten or any stated number, or to insert others in their place if thought more suitable. This is the course pursued in the preparation of the questions submitted herewith. A class of eighty-three presented themselves, one being rejected on account of insufficient credentials.

Action upon the reciprocity question was indefinitely postponed, and Secretary instructed to confer with Boards from contiguous states concerning the matter, and report later.

The examination developed one joker. In looking over some papers the following was discovered. "Question 2—Don't know. Wish to God I did." "Question 5—See Question 2."

Officers of King County Society for 1904.—At the annual meeting the following were elected: President, E. E. Heg; vice-president, I. M. Harrison; secretary, Carl Hoffman; treasurer, F. M. Carroll.

Officers of Skagit County Society for 1904.—The following have been elected as officers for the current year: President, A. C. Lewis; vice-president, Josiah Jones; secretary and treasurer, R. J. Cassel.

Officers of Chehalis County Society for 1904.—At the recent January meeting the officers of last year were re-elected: President, D. A. Schumacher; secretary, J. W. Scamell.

REPORTS OF SOCIETY MEETINGS.

KING COUNTY MEDICAL SOCIETY.

President, J. P. SWEENEY, M. D.; Secretary, CARL HOFFMAN, M. D.

The first regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce on the evening of December 7, 1903, President Sweeney being in the chair. Thirty-five members and visitors were present. G. W. Hawley was elected to membership. The names of H. Miller and F. T. Maxson were proposed and referred to the proper committee.

Dr. Eagleson spoke on the matter of inviting the American Medical Association to meet in Seattle in 1905, reading letters received from various sources bearing on the question. He stated that nothing definite could yet be stated as to progress. It was voted that the President appoint a committee of three to take the matter in hand and report at a future meeting. He appointed Drs. Eagleson, Horton and Smith.

CLINICAL CASES.

Extensive Loss of Tissues of Face.—Dr. Smith presented a man of 52 years who received an injury from a gun cap, beneath left eye, about fifteen years ago. A sore soon appeared that was diagnosed epithelioma by some physicians, lupus by others. Several operations were performed of excising skin, always followed by recurrence. At last he fell into the hands of a cancer specialist of Philadelphia, who made a series of paste applications to the cheek, followed by poultices to remove sloughs. He took an anesthetic only once, when the eye was punctured and removed. This treatment continued four months, when the condition was about as at present. Now he wears a green patch extending from right ala of nose to left temporal region and from eye brow to moustache. Beneath this is a cavity, showing absence of left eye, most of malar bone and nose except the tip. To the right are seen the right turbinated bones; above, the ethmoid, roof of orbit and region of sphenoid. The openings into accessory sinuses are presented. The whole cavity is covered with healthy looking mucous membrane. At the right upper angle is a spongy mass, the size of a walnut, which the patient says has been there for ten years. He retains the sense of smell. There is no troublesome discharge. About the edges considerable new skin has grown into the cavity. He has often been advised to have a plastic operation, but says he is satisfied with the present condition.

Schede's Operation.—Dr. Ford presented a patient on whom this operation had been performed, with the following history:

L. H., age 32. Previous and family history negative. On March 28, 1901, while steering a steamer in rough water, was thrown over the wheel with considerable force. He was unable to get up and had to be carried to his room. He suffered from severe pain in side and shortness of breath. He reached Seattle on April 1, and was admitted to hospital with a diagnosis of pneumonia, which was afterwards changed to acute pulmonary tuberculosis. On May 8 he came under my care, at which time he was greatly emaciated, had a fast and feeble pulse, elevation of temperature ranging from 100° to 103°, and was sweating profusely. He complained of pain in right side and had great difficulty in breathing. Physical signs and symptoms plainly showed it to be a case of pyo-pneumo-thorax. He was in a very critical condition and any operative procedure must necessarily be short. Removed a section from the fifth and sixth ribs, in front at the nipple line, and from the eighth and ninth behind, at the post-axillary line. The pleural cavity was partly filled with pus and the right lung compressed against spine. The patient began to improve immediately after the operation and in the course of three or four weeks was a great deal better. The openings continued to discharge, so I decided to perform a more radical operation. On August 2 I made a vertical incision, in mid-axillary line, going well up, and resected the ends of all the ribs from the third to ninth. He improved in strength and late in August left the city.

The wound did not entirely heal and when I saw him in July, 1902: it was still discharging and he had some septic symptoms. I decided to perform Schede's operation, which was done on July 14. The ends of ribs that had been resected at the previous operation were found necrosed and they were removed back to healthy bone, well beyond the edge of cavity. As much of the pleura as possible was removed at the same time.

The man made a good recovery from operation and improved very much. He left Seattle in November, at which time the wound had not completely closed. The discharge from wound continued and in May, 1903, he was operated upon by some surgeon in Minneapolis. The incision used resembled a large W, the middle point being in axilla, the posterior between angle of scapula and vertebral column, and the anterior extending to nipple line. This has been a complete success, for the wound closed about four months after operation and the man has remained well since. At the present time the right lung fills what remains of the right half of the thoracic cavity and appears to be doing good work. I show this man because his case is a rare and interesting one and it proves that very radical measures must sometimes be taken for the complete relief of this condition.

PAPER AND DISCUSSION.

The Safety of Operation in Appendicitis.—Dr. Willis read this paper and stated, at the outset, that we must distinguish between danger from the operation and a pathologic condition previously existing. Deaths from the latter have often been ascribed to the former. He reported a series of thirty appendectomies with no deaths, during the past year. Five presented ruptured appendices; three were subacute; seven chronic; five removed between attacks; four were healthy and removed during operation for other causes. Drainage was used only in presence of an abscess. He found lavage useful to relieve vomiting and abdominal distension. He detailed several cases to illustrate special points. He believed operation was demanded in practically all cases where the diagnosis is definitely established, except those late cases in which the Ochsner treatment is suitable. He described this plan of treatment, reporting success in a few that he had thus managed. He deprecated the view that an interval operation is preferable to one during the early hours of an acute attack. He has treated a number of patients without operation for various reasons. As far as he can ascertain their subsequent histories they can be divided into those who have had farther trouble or those who will have it. He concluded as follows:

1. Where conditions are favorable for operation this treatment is safer for all uncomplicated cases.

2. When complicated by purulent peritonitis or disease of other organs, it is often a serious question which treatment to choose, but probably a considerable proportion are better without operation.

3. No operation should be performed, except an emergency as opening an abscess, unless careful asepsis can be maintained.

Dr. Harris stated he had been Dr. Ochsner's interne for eighteen months. In most cases he operated within the first twenty-four hours. If perforation were present he followed the starvation treatment, which is ideal in the presence of peritonitis. Some cases were sustained by rectal nourishment so long as three weeks and then operation followed. He would not favor operation till pus was walled off.

Dr. Read said that the floculent material that often comes from the abdominal cavity at an operation is usually sterile.

Dr. Winslow spoke of the importance of properly closing the abdominal wall. The McBurney splitting incision is not much used in this locality. He approved overlapping of the external oblique fascia.

Dr. Eagleson said he was never successful with the McBurney incision. He thought it difficult of proper execution. He preferred going through the outer border of the right rectus. He mentioned the occasional presence of the appendix on the left side and described an autopsy where it was found fixed to the left of the median line. He commended the Ochsner treatment, describing the case of a man of 72, now under observation, who appeared with distended abdomen, rapid pulse, stercoraceous vomiting. Under this treatment all symptoms disappeared, including the tumor about the appendix.

Dr. Smith reviewed the history of appendectomy, mentioning the scattered early cases, soon followed by an epidemic of operating on all patients with pain about the cecum, and a later conservatism that permitted some to survive without the use of the knife. He believed a certain proportion of cases would recover from one attack and never experience another, though he admitted this might be due to their not living long enough.

Dr. Sharples thought that, after a patient has had one attack we don't know what is his condition. The appendix is like a fuse that may be touched off at any time. He related the case of a man with mild symptoms who insisted on an operation though he thought it unnecessary. He found the appendix in a state approaching perforation.

Dr. Winslow mentioned the fact described by several writers where, after repeated attacks, the appendix has become obliterated, which explains the recovery of some cases.

Dr. Ford called attention to the danger of obstruction of the bowels from frequent attacks and described a case where several inches of the small intestine were reduced to the size of a lead pencil from this cause.

The second regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce on the evening of December 21, 1903, President Sweeney being in the chair. Forty members and visitors were present. Drs. H. Miller and Maxson were elected to membership and the name of Dr. H. G. Lazelle proposed.

The President appointed a committee, composed of Drs. Hoffman, Peterkin and Carroll, to arrange for the annual banquet, which would be held on the evening of the first Monday of January.

ADDRESS.

The President's Annual Address.—President Sweeney read his annual address, first mentioning some of the conditions existing during the early years of practice in the Northwest. He gave the names of some pioneer practitioners and incidents of interest concerning them. He expressed his pleasure at the prosperity of the society during the past year and some facts that have occurred. Mention was made of the Washington Medical Library Association, the establishment of NORTHWEST MEDICINE, and the pathologic laboratory. He thought more conservatism had been exhibited in surgery of late and that care in this line would tend to suppress some medical fads that thrive through fear of surgery on the part of the public. He referred to the pressing need of greater hospital facilities in Seattle; also expressed his views on the evils of lodge doctoring for a mere pittance. The disregard of the local Board of Health on part of the city officials was described and the benefit that would accrue if all matters of public health were referred to this board and removed from political influence. He referred to the many new physicians now coming to the state and extended to them a cordial welcome, provided they be qualified practitioners and practice as gentlemen.

Dr. Holmes replied to the President, in expressive and fitting language, stating that he voiced the sentiments of the society in thanking him for the efficient and impartial manner in which he had presided over the meetings of the society during the past year. That this had been the most successful and profitable year in the history of the society he attributed largely to his personality and influence. He wished to take this occasion to say that his past labors would long be cherished in the hearts of his associates and he trusted he might long remain with them in person.

The Secretary's Annual Report.—Dr. Hoffman presented the following statistics as to the proceedings of the society during 1903:

Number of members in good standing January 1, 1903..........	99
Number of members in good standing December 21, 1903.......	110
Number of honorary members December 21, 1903..............	3
Amount collected during 1903, dues and initiation............	$609.00
Amount paid out, including State Association dues.............	476.45
Balance on hand..	$133.55

Number of applications for membership, 1903	21
Number of members elected during 1903	20
Number of honorary members elected during 1903	3
Number of members dropped for non-payment of dues	6
Number of members expelled	1
Number of meetings during 1903	21
Number of papers read	27
Number of cases exhibited	19
Number of pathologic specimens exhibited	24
Number of discussions of papers, cases and specimens	168
Average attendance at meetings	33

The President appointed Dr. Holmes to audit the Secretary's financial statement and to report at the next meeting of the society.

WHATCOM COUNTY MEDICAL SOCIETY.

President, C. L. Holt, M. D.; Secretary, F. J. Van Kirk, M. D.

The regular monthly meeting of the Whatcom County Medical Society was held on Monday, December 14, 1903.

The meeting was held in the banquet room of Hotel Byron, where a sumptuous supper was given, in honor of Dr. Frantz H. Coe, President of the State Medical Association.

After a somewhat lengthy social entertainment the regular program of the evening was taken up.

President Holt, in a few chosen remarks, welcomed Dr. Coe to our meeting.

PAPER AND DISCUSSION.

Diagnosis of Deranged Kidney Function.—Dr. Frantz H. Coe presented the paper of the evening, with this title. The subject of urinalysis was first taken up, to show how inadequate the usual methods were, where applied to the diagnosis of kidney lesions. The various urinalysis tests were carefully considered, with a view of eliminating any possible error, arising from defective technic. The operation for decapsulation was carefully explained and the society listened with marked attention as the doctor described the results of the operation upon himself, in the hands of Dr. Edebohls, and his subsequent experience in many private cases.

The exact nature of the undoubted improvement and possible cure of Bright's disease by decapsulation is now being considered by the best physiologic chemists of this country and Europe. The thought is certainly inspiring that we may be able, in the near future, to diagnose perverted metabolism which precedes the kidney lesion and correct it before irreparable injury is suffered by this vital organ. The doctor thought that, in view of our present knowledge of the results of decapsulation, we were certainly justified in many otherwise hopeless cases. The paper was discussed by Drs. Biggs, Kirkpatrick and A. Macrae Smith.

After the regular program Dr. Coe, as President of the State Medical Association, delivered a few remarks upon the subject of state and county organization and particularly dwelt upon the necessity of harmony among the individual members.

The society, by a vote of thanks, expressed their appreciation of Dr. Coe's genial personality and the pleasure of his presence which had made this one of the most enjoyable gatherings of the year.

The meeting adjourned to meet the second Monday in January.

CHEHALIS COUNTY MEDICAL SOCIETY.

President, D. A. Schumacher, M. D.; Secretary, J. W. Scamell, M. D.

The regular meeting of the Chehalis County Medical Society was held at Aberdeen Tuesday evening, Jan. 5, 1904. A fair attendance and a very enjoyable time. The present officers were re-elected for the ensuing year.

PAPERS AND DISCUSSIONS.

Medical Treatment of Lacerated Cervix.—Dr. M. L. Pearson, of Aberdeen, read this paper. He said no line of treatment will cure lacerated cervix and surgical measures only are of avail. However, there is a low grade of inflammation present in most cases and a great deal can be done by proper applications to the cervix. In his judgment operation is not indicated until such treatment is carried out. He uses tampons of glycerine with various indications and, where indolent ulceration exists, applies Churchill's caustic tincture iodine every third to fifth day. Build up general health as far as possible. Do not apply any remedies inside the uterus.

In opening the discussion, Dr. Stapp, of Aberdeen, said: I usually refer cases of lacerated cervix to Dr. Pearson for a season of treatment before operation, and I find results very satisfactory.

Dr. Walston, of Montesano, suggested hot water douches in conjunction with tampon treatments but did not believe in any preliminary treatment to any extent.

Dr. Schumacher, of Aberdeen, believes in scarifying the cervix to relieve engorgement during treatment.

Dr. Scamell, of Aberdeen, said: Better operative results are secured by a prior treatment of three to six weeks. The congestion is considerably relieved the os becomes firmer and the flabby, soft condition much obliterated, which leaves opportunity for a better removal of all scar tissue, better coaptation of flaps, and better holding of the stitches.

Extra-Uterine Pregnancy.—Dr. Scamell read a paper on this subject, his personal experience being limited to two cases. One was operated on successfully at two and one half months, the other being unrecognized until after death.

RECENT PROGRESS IN MEDICINE AND SURGERY.

SURGERY.

Edited by

J. B. Eagleson, M. D., K. A. J. Mackenzie, M. D., E. E. Heg, M. D.,
SEATTLE. PORTLAND. SEATTLE.

The Operative Treatment of Chronic Bright's Disease (By Ramon Guiteras, M. D., New York Medical Journal, November 11, 1903.)

The author discusses the subject under five subdivisions: 1. "What is Chronic Bright's Disease?" and states that in order to have a true nephritis we must have an inflammation or degeneration of the blood vessels, the interstitial tissue, the glomeruli, or the epethelia lining the tubules of the kidney, which occurs in both kidneys but may vary in degree in different organs. Many cases of albuminuria and cylindruria are not Bright's disease but if the cause producing them are kept up long enough, chronic nephritis may occur, as with a movable kidney. Pousson believes a sympathetic relation exists between the kidneys, as between the eyes and an operation on one may relieve the other.

2. "In what does the operation consist that is supposed to cure or relieve it?" Two kinds of operation have been advocated: first, partial decapsulation of one or both kidneys and fastening the denuded surface to the abdominal wall; second, entire peeling off the capsula propia. While the latter has largely superceded the former, the author considers partial decapsulation the better. He believes with Ferguson that the study of the macroscopic and microscopic conditions of the organ are essential and it is proper to remove the V shaped piece of the cortical and pyramidal tissue.

3. "The arguments for and against this operation": Theoretically the benefit is from increased circulation from anastomosis with the abdominal walls or fatty capsule, aiding functional activity of the kidney. He agrees with Edebohls that by increased circulation destroyed epithelia may be restored and, if the increased circulation is maintained, may become capable of carrying on the secretory function, but doubts the regeneration of sclerosed blood vessels or the restoration to nominal of the interstitial tissue in interstitial nephritis. Better circulation would seem to occur from attaching a partially decapsulated kidney to the posterior abdominal wall than from the fatty capsule, though Edebohls claims in a recent autopsy quite liarge vessels were found penetrating the renal tissue through the newly formed capsula propia from the fatty capsule. On the other hand, Johnson's experiments on dogs show the capsule is reconstructed in three and one-half months with no considerable anastomosis between the renal and perirenal blood channels; hence the author believes the reconstructed capsula propria will, by pressure and contraction, diminish the blood supply of the kidney and make it less than before the operation and the chance for improvement is temporary; splitting the capsula will relieve the tension and it is not necessary to entirely

decapsulate for such relief. He believes we should treat chronic Bright's disease conservatively as long as the patient is comfortable and the time for operation is when the process is rapidly advancing with danger of over taxing the heart.

4. "Symptoms which have lead various surgeons to operate." Among symptoms are pain, digestive symptoms, progressive weakness, anemia, eye symptoms, cardiac palpitation, tachycardia, dyspnea, urinary symptoms and nervous symptoms, edema, anasarca, etc. Many consider an operation imperative when there is anasarca with a feeble heart, but 50 per cent. die, 25 per cent. improve temporarily and then die. Marked suppression or anuria are considered imperative indications for operations; remarkable results are sometimes obtained with complete failure in other cases. Movable kidneys with nephritis and diffuse nephritis are considered favorable for operation but the author thinks diffuse nephritis most unfavorable as 75 per cent die.

5. "Results.' The best results are in cases of movable kidney showing symptoms of Bright's disease; usually it is not necessary to operate on the unmovable mate. In one hundred and twenty cases the percentage cured was 16 per cent., improved 40 per cent., unimproved 11 per cent., deaths 33 per cent. Cases of interstitial nephritis often showed brilliant results. Mortality in chronic interstitial nephritis was 25 per cent., in chronic parenchymatous 25 per cent., in chronic diffuse 75 per cent.

His conclusions are: 1st. Chronic nephritis should not be operated upon until medical treatment fails. 2nd. Time for operation is when disease is advancing and heart in danger of being overtaxed. 3rd. The least danger and the best results are from nephropexy on a single, movable kidney. 4. Most unfavorable cases are of diffuse nephritis. 5. Cases of general anasarca with bad heart should not be operated upon; with good heart can possibly add a few months to life. 6. Operation relieves cases with marked destructive process for short time only; they usually fail and die when the new capsule begins to contract.

HEG.

One Thousand Abdominal Closures, by a New Method, Without a Known Hernia. (By Baldwin, Annals of Surgery, November, 1903.)

The writer states that he has used this method in one thousand cases since 1897, without a known hernia. He uses No. 26 annealed iron wire, tinned, such as can be obtained in any hardware store.

His method is described as follows:

1. The bellies of both recti are exposed so that they will be brought into direct apposition when sutures are tightened.

2. Through-and-through silkworm gut is then introduced, *from within out*, so as to catch the edge of the peritoneum, then going well back into inside fascia and skin.

3. The fascia is brought together loosely by a coarse silk or cotton continuous stitch with a long loop, by means of which the iron wire is drawn through, care being taken to have fascia well freed from fat, and that the stitch penetrates deeply into it.

4. Each end of the wire is brought out through the skin about one

inch above and below the ends of the wound and made to pass through a gauze pad, over which a perforated shot is placed.

5. The wound being carefully dried, while an assistant draws up the silkworm gut sutures so as to coaptate the peritoneum, the wire is drawn straight by traction on each end, care being taken to see that no kinks are formed in it. It should be drawn back and forth once or twice to see that it is freely movable. The perforated shot are now pushed down against the gauze pads and clamped. This holds the fascia in absolute contact.

6. The silkworm gut sutures are then tied, being careful not to draw them too tight. These preclude any possibility of dead spaces in the tissues.

In case the recti muscles are widely separated, no attempt is made to bring them together, but extra care is taken to secure apposition of the fascia. The dressings are retained by a many tailed bandage and, if the case does well, are not removed until the tenth day.

The wire suture is easily removed by cutting one end at skin and drawing it through.

The author claims for this wire that it is inexpensive, elastic, and easily sterilized. EAGLESON.

DISEASES OF CHILDREN.

Edited by

G. B. McCulloch, M. D.,	G. S. Hicks, M. D.,	C. B. Ford, M. D.,
SEATTLE.	TACOMA.	SEATTLE.

The Relation of the Status Lymphaticus to Sudden Death, Death Under Anesthesia, and Infection. (By Dr. George Blumer, Johns Hopkins Hospital Bulletin, Nov., 1903.)

Sudden death, associated with hyperplasia of the thymus gland and the lymphatic apparatus in general, status lymphaticus, has been much discussed in recent years. Some articles call attention to the similarity which exists between the lesions of this form of sudden death, and many cases of death under anesthesia, while some suggest a relationship between sudden death during infectious diseases and the status lymphaticus. All three classes are important from a professional and medico-legal point of view.

Every practitioner should recognize the existence of a class of individuals that are extremely susceptible to shocks of various kinds, physical, psychic and toxic, which may lead to their sudden death from accidents which, to the ordinary individual, would be trivial. Some have died from so trivial an operation as the hypodermic injection of a standard remedial agent, some from the shock caused by a plunge into cold water. A number of cases are on record where nurse maids have been accused of suffocating infants, the true cause of beath being shown by the autopsy to be the status lymphaticus. There is no constant relationship of the status lymphaticus with epilepsy, rachitis or exopthalmic goitre.

The object of this paper is to show the common factor which underlies cases of sudden death, associated with the "status lymphaticus," whether they occur spontaneously or under the influence of a chemical (anesthesia) or bacterial (infection) poison. Is it possible to make a diagnosis of the status lymphaticus before the onset of the attack which is the immediate cause of death? Certain clinicians believe that individuals who are subjects of the lymphatic constitution can, in many cases, be recognized. Escherich states that they usually have a pale, thin skin, a pasty complexion, and a good pad of subcutaneous fat. Frequently signs of rachitis or scrofula are present. The superficial lymph glands, especially those of the neck and axilla, are enlarged. There is hypertrophy of the tonsils, the circumvallate papillae of the tongue and the pharyngeal lymphatic apparatus (adenoids). The spleen is often palpable. It is said that a percussable thymus may develop later. Ewing suggests that an increase in the lymphocytes of the blood is in all likelihood present.

Our knowledge of the clinical symptoms of these cases relates mainly to the appearance observed immediately or shortly before death. The majority of these patients are apparently in perfect health up to within a short time of the fatal issue. The clinical picture varies in different cases and we shall attempt to classify the cases according to the clinical features, though the immediate causes of death are probably only two, cardiac paralysis and asphyxia.

Cases found dead in bed. This type of death usually occurs in young infants and most of the cases in which foul play has been suspected are of this nature. The manner of death is of necessity uncertain; at the same time there are grounds for believing that the infants are not perfectly well for a short time before death, and probably death takes place in a convulsive seizure.

Cases of sudden death, presumably of cardiac origin. Under this head we may reasonably place cases where the death was very sudden and not preceded by respiratory disturbances. Where sudden immersion in cold water is followed by instant death they belong to this class. also some of those found dead in bed.

Cases of sudden death, presumably of respiratory origin. These may be classed under the head of thymic asthma. They do not all present the same clinical picture; in some instances the child dies in the first attack or series of attacks, while in other cases the condition may last for a week or even years and finally terminate in a fatal attack or relief by operation. The operative procedures thus far resorted to in these cases have been total extirpation of the gland or partial extirpation and pulling upward of the gland, the portion left behind being anchored to the sternum high up. Cases in which the child dies during an acute attack are more common than cases running a protracted course. Some cases die with signs of suffocation and without definite asthmatic seizures.

Cases of sudden death, presumably of nervous origin. Some of these have died very suddenly during a spasm. Laub describes a cerebral form of death from status lymphaticus. It usually occurs in young adults and causes death in a few hours, eighteen at the outside. They are suddenly attacked with coma and perhaps convulsions.

The relation of the status lymphaticus to death during anesthesia. All agree that in these cases death is due to cardiac failure. The respiration persists after the heart has stopped. Chloroform, ether and A. C. E. mixture are all dangerous. In some cases premonitory symptoms are observed, in many instances death is instantaneous. Two classes of patients are especially liable to this accident, those with goitre and those with adenoid vegetation.

The relation of the status lymphaticus to infection. Over a quarter of the patients dying from diphtheria, in Escherich's clinic, present the picture of status lymphaticus. The clinical picture was modified in some cases. Some cases of tetanus and streptococcus infection are modified by this condition.

The pathologic anatomy. Gross lesions consist of a hyperplasia of the thymus gland, and the lymphatic tissue of the body in general. Hypoplasia of the vascular system is found in some cases.

Histology of the lymphatic apparatus and thymus in status lymphaticus. In the thymus gland general hyperplasia of the lymphoid elements, at times proliferation of the endothelial cells along the trabeculae. In the other places general hyperplasia with focal changes.

The bacteriology of the status lymphaticus. Outside of cases definitely stated to be infected cultures were sterile. Some other factor than bacterial infection must be held responsible for the lesions in most cases.

Causes of death in status lymphaticus. Two theories. One assumes that death is due to mechanical pressure of the enlarged thymus; the other that it is due directly to cardiac paralysis and indirectly to some form of toxemia. We believe that the condition which is present is one of lymphotoxemia.

Conclusions—

1. The condition known as the status lymphaticus is a definite pathologic entity.
2. It is probably associated with, if not due to, a condition of intermittent lymphotoxemia.
3. It may be associated with sudden death, probably as a result of lymphotoxemia alone in some cases, or as a result of the action of toxic, physical or psychic injuries, which are rendered much more powerful than usual by the predisposing action of the lymphotoxemia.
4. In some cases the sudden death is undoubtedly mechanical and due to asphyxia from pressure of the enlarged thymus on the trachea.
5. The subjects of the status lymphaticus can be recognized chemically in some instances.

FORD.

The Prognosis and Orthopedic Treatment of Acute Anterior Poliomyelitis. (By Walter G. Stern, M. D., N. Y. Med. Jour. Sept. 5 and 12, 1903.)

The writer says the course of poliomyelitis is naturally divided into two stages, the acute and the chronic. During the latter the prognosis and orthopedic treatment are called into question.

The prognosis of any case may be viewed from two standpoints: that of the ultimate recovery of physiologic activity in any individual nerve, muscle or joint, and the return of functional usefulness in the affected member. The ultimate recovery of physiologic activity depends upon the pathology of the disease and the physiology of recovery.

The disease is due to the inflammation and degeneration of the large multipolar ganglion cells in the anterior horn of the spinal cord; is an acute infection, and therefore self limiting. Infectious multiple neuritis complicates most of the severe cases and gives rise to many of the immediate paralyses.

The physiology of recovery lies in the transference of the power to originate nervous activity from one set of cells to another; for example, when a flexor muscle is finally enabled to co-ordinate with the extensions of the other limb, after the tendon has been transplanted; and in nerve regeneration.

The prognosis as to spontaneous recovery of activity depends upon the ability to recognize the kind and extent of the lesion, and the power of the organism to recover from it, both difficult problems. The extent of the pathologic lesion is best estimated by simple observation. It is directly in proportion to the amount of paralysis of the voluntary muscles, and may be approximately mapped out. There is no way of ascertaining how much multiple neuritis there is, except by the amount of pain experienced by the patient when pressure is applied over the nerve trunk.

In no disease is the reaction of the muscles to the faradaic current lost so early as in anterior poliomyelitis. Where such a change has occurred, the return of the power of the faradaic current to produce contractions means recovery of voluntary control, and the earlier it returns the more rapid and complete will be the recovery. *This is the only positive electrical test upon which all authorities agree.*

"May the faradaic irritability be absent until the degeneration is so complete that recovery of voluntary control motion is impossible?" Authorities differ upon this point all the way from ten days to two years. Some place no limit, and the writer's experience has led him to the same conclusion.

The Resistance Test for determining what muscles will recover has been advanced by Regnier. He calls the effort to raise the arm (for instance) positive; the effort to hold it in this position, negative. Another negative form would be the contraction of one group of muscles while trying to contract another. The problem sought is to demand a minimum of muscular effort while inducing the corresponding motor cells to exert a maximum of energy, thus overcoming the resistance of degenerated nerve elements. The process of making these tests is simple. The limb is raised to a determined height and held there, at the same time applying firm pressure to the part of the limb to be tested, as near to the periphery as possible, the pressure bearing mostly on the tendons. The muscles are now all made to contract, which brings out a reflex negative contracture of the afflicted ones, the intensity being proportional to the excitability of the motor cell. Thus we have a number of methods which permit us to say with great certainty that certain muscles will recover, but none to say definitely which are hopelessly lost.

Treatment—He begins orthopedic treatment as soon as acute symptoms subside, having five objects in view:

First—To promote spontaneous recovery and to stimulate the return of activity.

Second—To prevent deformity.

Third—To cure deformity.

Fourth—To restore the joint equilibrium, to make good lost power, and perfect functional recovery.

Fifth—To destroy dangle joints and convert the limb into a useful stump.

He asserts that the sheet anchor of all expectant treatment is electricity, as it keeps up a muscular and nervous activity which more nearly approaches the physiologic. Where the faradaic irritability is lost he uses a slowly interrupted galvanic current, applied over the belly of the muscle, by large moist electrodes. When faradaic irritability returns he stimulates the nerves and muscles with a slowly interrupted current, having found electrical massage, brushes and electrical baths worse than useless. To this treatment he adds ordinary hot baths and massage from fifteen to thirty minutes a day, which stimulates the muscles and favors the regeneration of the nerve from the muscle end-plates upward.

He also advocates passive motion and gymnastics. If only a toe can be moved, the patient is placed in the saddle of a walking machine and taught to use that toe. If the spine is paralyzed a corset is attached to the machine to enable the patient to sit erect. Gymnastics and passive motion will, together with a light brace, prevent deformity in every case.

After two or three years of active treatment, when spontaneous recovery has replaced all the lost power possible, he proceeds by operative interference to restore joint equilibrium and repair lost motion. First correcting existing deformity, he makes a careful study of the condition and power of the muscle by the use of electricity and dynamometers. Always keeping in mind the axiom that surgical intervention cannot add to the muscular energy present, but can only distribute it where most useful, he then proceeds to utilize certain chosen muscles for tendon transplantation.

There are four ways of transplanting tendons:

1. Active transplantation; dividing the active tendon and uniting it to the tendon of the paralyzed muscle.
2. Passive transplantation; severing the tendon of the paralyzed muscle and uniting the distal end to the uncut tendon of the healthy muscle.
3. Partial transplantation; splitting the tendon of an active muscle and uniting part of it to a paralyzed muscle.
4. Periostial implantation of the whole or a portion of the healthy tendon.

The results of tendon transplantation have been uniformly good. Extensor muscles have learned to act as fluxors, and vice versa, and where a tendon has been split, one muscle has even successfully performed these two distinct functions. Franke writes: "There is no longer a hopeless case of musculospiral palsy since we can do tendoplastic operation." Drobnick states: "It puts new life into the limb."

When tendon transplantation is denied he substitutes braces, elastic bands, springs and sword blades, but asserts that the spring brace lacks the essentials of the normal muscular contraction, the last quarter of the arc of motion, necessary for full extension or flexion, being always the weakest.

Flail joints and dangle limbs he resects, producing solid stumps, which is a perfect substitute for amputation and artificial limbs, to which he never resorts. McCulloch.

BOOK REVIEWS.

Edited by
KENELM WINSLOW, M. D.

The Aetiology, Pathology, Diagnosis and Treatment of Tumors. By A. Hamilton Levings, M. D., Milwaukee, Wis., Professor of the Principles and Practice of Surgery and Clinical Surgery in the Wisconsin College of Physicians and Surgeons; Surgeon to St. Joseph's, Milwaukee County and Mount Sinai Hospitals; Consulting Surgeon to Johnson's Emergency Hospital and to the Milwaukee County Hospitals for Acute and Chronic Insane. 259 illustrations, including many colored plates. Cleveland Press, Chicago, 1903. Half-leather, $5.00.

The subject is viewed from the standpoint of the surgeon rather than the pathologist, the expression is clear, the style pleasing, the reading interesting; the author cites many clinical cases to illustrate his prints. Many pages are devoted to the technic of an operation, including the details of preparation of the patient, operator, instruments, etc; much normal histology inserted, prolonged description and technic of various operations given. The value of the book would have been materially increased for reference purposes, had the author arranged and carefully planned an index, with cross references; but this point has been apparently overlooked, the index being too meagre.

In his preface, the author states that he has followed as a basis for classification of tumors that of structure rather than of origin. He devotes the first seven chapters to general considerations and classification of tumors, the next fourteen to the various so-called benign tumors, taking up each class under a separate chapter; while in the last five chapters the malignant varietiy of tumor is considered in order, its histology, origin, the various organs and structures in which it may occur, with symptoms, course, diagnosis, prognosis and treatment.

Many chapters are full and very complete, those on myomata and endotheliomata being especially good. Over a hundred pages are devoted to cystic tumors. Other subjects receive rather scant attention by comparison. The important subject of brain tumors, as given, is scattered through several chapters, requiring the personal of many pages to get the meat out. Syphilitic and tubercular tumors of the brain receive only passing mention. No reference occurs in the index to carcinoma of the liver and, though it may often be of secondary occurrence, it is certainly important enough to be discussed. No special chapter is devoted to tubercular or syphilitic formations, these being mentioned in various places under differential diagnosis, etc.

The book, however, has much in it to commend, shows careful research and collection of data. The author inclines toward the belief of parasitic origin of malignant growths, and says that, in the near future, he thinks the terms sarcoma and carcinoma will be relegated to the back shelf, and names more in accordance with and expressive of their etiology be substituted. Some of the statements made are rather too sweeping in character, while some of his conclusions drawn, from cases cited where no autopsy or microscopical examination was obtained, should be conjectural rather than positive.

He makes a strong plea for early operation in gastric corcinoma, believing that one should not wait for cachexia, hematemesis or evidence of growth by palpation, and states four points to be governed by, in justification of an exploratory operation. He says "In the past there has been too much of waiting and too great attention given to the apparent importance of frequent examination in the chemistry of the stomach contents and not enough surgery." LAZELLE.

EGBERT'S HYGIENE. New (3d) edition. A Manual of Hygiene and Sanitation by Seneca Egbert, M. D., Professor of Hygiene in the Medico-Chirurgical College of Philadelphia. New (3d) edition, enlarged and thoroughly revised, in one 12mo. volume of 467 pages, with 86 illustrations. Cloth $2.25 net. Lea Brothers & Co., Publishers, Philadelphia and New York.

In this book is to be found, first, a consideration of general bacteriology, including septicemia, toxemia, immunity, antitoxins and prophylactic infections. The contamination of air by impurities, poisons, dust, products of illuminating gas and sewer gas are next treated. An excellent chapter follows on heating and ventilation on both a large and small scale. Then water in regard to its sources, impurities, disease-producing possibilities and methods of purification receive careful attention. Succeeding this, the subject of food is taken up with a brief description of the physiology of digestion, the comparative value of the various nutrients, and detailed consideration of the nutritive worth of the common articles of diet—including tea, coffee and alcohol. Chapters on personal and school hygiene now attract our notice, the subjects necessarily receiving a rather brief review. The description of disinfection, the chapters on quarantine, and the removal and disposal of sewage, are however fully and ably expounded. The value and methods of presenting vital statistics constitute a practical chapter. The chapter on military hygiene is also an unlooked for feature of interest and value. The work closes with a description of the more useful tests for the determination of impurities in air, food and water.

The work is a concise, thoroughly reliable and well-considered condensation of the broad subject of hygiene. The brevity which is essential to this end renders the book necessarily liable to the shortcomings inseparable from such an attempt. In a treatise of this scope individuality, original views, style, philosophic discussion and completeness in all its parts must invariably be sacrificed. The writer has himself acknowledged this in the preface. On the other hand many of the topics are treated very thoroughly and the author has quoted and referred so copiously to other authorities throughout the book, with references appended thereto, that one can readily follow up the subject more exhaustively if so desired. As a trustworthy manual for students and laymen, and a handy book for easy reference for the physician, we heartily commend it. WINSLOW.

DISEASES OF METABOLISM AND NUTRITION. A Series of Monographs by Prof. Dr. Carl von Noorden. American Edition Edited by Boardman Reed, M. D. Part IV, The Acid Autointoxications. PP. 80; cloth 50 cents. E. B. Treat & Co., New York.

The many contributions of this original investigator and clinician are always of great interest. In the present monograph he presents the results of his work upon autointoxication with the acid group of acetone bodies, B oxybutyric acid, diacetic acid and acetone. He shows that these bodies differ only as a result of varying degrees of lessened oxidation in the body. Their origin is uncertain but their existence is directly proportional to the absence of a proper supply of carbohydrates in the food. The role of carbohydrates in this connection appears to be to supply oxygen for the combustion of these bodies into CO_2 and H_2O. Failure in the amount of carbohydrous food results in elimination of these bodies unchanged in the urine and an acid intoxication of the blood—or rather a lessened alkalinity of the blood —resulting in poisoning with nervous manifestations, convulsions and coma, notably in diabetes mellitus. Acetonuria (including the other acetone bodies) is often present in fevers, in carcinoma, in gastro-intestinal diseases, and as a source of epilepsy and convulsions in children, and is a recognized entity. In all these cases von Noorden asserts—and supports his assertion by numerous clinical and laboratory experiments—that the acid intoxication is not due to intestinal toxin-origin but wholly to lack of sufficient carbohydrate sustenance. Diabetic coma is now agreed on all sides to result directly from acid poisoning of the blood with the acetone group. In this disease, as in other conditions, the source of the acidosis is dependent on failure of proper supply of carbohydrates in the food. In no condition is the degree of acetonuria so marked. Here, as elsewhere, the addition of carbohydrates will diminish and abolish the acidemia, nevertheless. In order to accomplish this result, without increasing the glycosuria, von Noorden relies on dextrose and dietaries which have proved clinically most satisfactory in preventing acetone acidosis and its result —diabetic coma. Alkalies are also most valuable given in large amounts continuously throughout the disease and diabetic coma is sometimes overcome by the intravenous injection of sodium carbonate solution.

The whole subject of metabolic disorders is a fascinating one and the present topic is as ably and logically presented as the former contributions of this writer. His work is along a line which will probably lead to the greatest discoveries in medicine in the coming years, that is physiological chemistry. The perusal of this little volume is not only a pleasure but a positive privilege, especially when the translation is so well done. WINSLOW.

REPORT OF CONTAGIOUS DISEASES.

To the Washington State Board of Health for December, 1903.

Counties.	Smallpox		Scarlet Fever		Diphtheria		Typhoid Fever	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Adams	1	0	6	0	1	0	0	0
Chehalis	3	0	0	0	0	0	4	1
Chelan	0	0	3	0	3	1	0	0
Clallam	0	0	1	0	0	0	0	0
Columbia	0	0	2	0	1	1	0	0
Douglas	0	0	0	0	0	0	2	0
King	0	0	21	0	0	0	4	0
Kittitas	1	0	3	0	0	0	3	0
Klickit'at	7	0	0	0	0	0	0	0
Lincoln	2	0	0	0	4	1	0	0
Snohomish	0	0	9	1	8	0	0	0
Spokane	1	0	4	0	6	1	2	0
Stevens	0	0	0	0	2	0	0	0
Wahkiakum	0	0	1	0	0	0	0	0
Walla Walla	7	0	2	0	1	0	10	0
Whatcom	1	0	2	1	4	1	1	1
Whitman	1	0	5	0	1	0	1	0
Yakima	0	0	5	0	3	3	3	0
Seattle (city)	1	0	48	1	4	1	7	4
Spokane (city)	4	2	8	1	9	1	0	3
Tacoma (city)	0	0	6	0	5	0	16	4
Totals	29	2	126	4	52	10	53	13

ELMER E. HEG, Secretary.

MEDICAL SOCIETIES.

Name. Meetings Held.

Washington State Medical Association..................1904—Seattle
President, F. H. Coe, M. D.; Secretary, A. H. Coe, M. D.

Chehalis County Society ....Second Tuesday—Aberdeen
President, D. A. Schumacher, M. D.; Secretary, J. W. Scamell, M. D.

King County Society ....First and Third Monday—Seattle
President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

Pacific County Society ....
............Third Monday of Jan., April, July, Oct.—South Bend
President, G. W. Overmeyer, M. D.; Secretary, Mary W. Gunwell, M. D.

Pierce County Society...........Second and Fourth Tuesday—Tacoma
President, Hamilton Allan, M. D.; Secretary, George McGeer, M. D.

Skagit County Society ....
President, A. C. Lewis, M. D.; Secretary, R. J. Cassel, M. D.

Snohomish County Society..................First Thursday—Everett
President, W. C. Cox, M. D.; Secretary, C. B. Betts, M. D.

Spokane County Society...................First Thursday—Spokane
President, C. S. Kalb, M. D.; Secretary, Geo. A. Gray, M. D.

Walla Walla County Society.........Second Wednesday—Walla Walla
President, N. G. Blalock, M. D.; Secretary, Y. C. Blalock, M. D.

Whatcom County Society.................Second Monday—Whatcom
President, D. E. Biggs, M. D.; Secretary, W. N. Hunt, M. D.

Whitman County Society ....Oct. 2—Tekoa
President, G. B. Wilson, M. D.; Secretary, E. Maguire, M. D.

Yakima County Society..............First Tuesday—North Yakima
President, T. B. Gunn, M. D.; Secretary, David Rosser, M. D.

Oregon State Medical Association.....................1904—Portland
President, W. T. Williamson, M. D.; Secretary, L. H. Hamilton, M. D.

City and County Medical Society of Portland...First Wed.—Portland
President, R. L. Gillespie, M. D.; Secretary, A. D. Mackenzie, M. D.

Multnomah County Medical Society..........First Tuesday—Portland
President, E. M. Crockett, M. D.; Secretary, L. Victoria Hampton, M. D.

Montana State Medical Association......................1904—Butte
President, T. J. McKenzie, M. D.; Secretary, B. C. Brooke, M. D.

Silver Bow Medical Society....Second and Fourth Wednesdays—Butte
President, T. J. Sullivan, M. D.; Secretary, Grace W. Cahoon, M. D.

Idaho State Medical Association ....1904—Lewiston
President, J. L. Conant, Jr.; Secretary, E. E. Maxey, M. D.

Northern Idaho District Medical Society.............June 9—Lewiston
President, C. L. Gritman, M. D.; Secretary, C. D. Parsons, M. D.

Southern Idaho District Medical Society................July—Hailey
President, W. E. Hargrave, M. D.; Secretary, R. E. Smith, M. D.

British Columbia Medical Association...............1904—Vancouver
President, O. M. Jones, M. D.; Secretary, W. D. Brydone-Jack, M. D.

Vancouver Medical Society ....Vancouver
President, A. P. Proctor, M. D.; Secretary, J. S. Conklin, M. D.

New Westminster Medical Society.Fourth Thursday—New Westminster

Corrections and additions to this list are requested from societies reached by this journal.

SEATTLE NURSES' BUREAU

If you need the services of a Graduated Nurse call on the Superintendent

MRS. A. W. HAWLEY

1115 Madison Street, or Phone John 411, and she can supply you on short notice.

Graduated Nurses' Association

NAME.	QUALIFICATION.
BEAN, MISS ALTA	Graduate Grace Hospital, Detroit.
BECHDOLT, MISS MARGARET	Graduate Seattle General Hospital.
BLASHFIELD, MISS ELLA	Graduate U. B. A., Grand Rapids, Mich.
BARR, MRS. EMMA L.	Garduate Mt. Sinai Hospital, New York.
BUTTON, MISS AGUSTA	Graduate Seattle General Hospital.
BAKENHUS, MISS MELINDA	Graduate Bethesda Hospital, Chicago.
BENDER, MISS JULIA M.	Graduate Eastern Illinois Hospital.
BRYSLAND, MRS. LILLIAN	Gradate Seattle General Hospital.
CROWL, MISS FLORENCE I.	Graduate Seattle General Hospital.
DAM, MRS. EVA L.	Graduate Seattle General Hospital.
DE VECKMON, MRS. E.	Graduate Seattle General Hospital.
FREMMING, MISS THORA H.	Graduate City and County Hospital, St. Paul.
FEEHAN, MISS ANNA	Graduate St. Joseph's Hospital, St. Paul.
MISS ROSE FINDLEY	Graduate Victoria Jubilee, Dominion General Hospital, Kingston.
GILLISPIE, MISS CORA E.	Graduate Illinois Training School for Nurses.
GREEN, MRS. ANNIE G.	Graduate Good Samaritan Hospital, Portland.
GREGG, MISS MINNIE	Graduate Women's Hospital, Syracuse, N. Y.
HUGHES, MISS M. A.	Graduate Dublin General Hospital.
HUBBS, MRS. F. H.	Graduate Philadelphia Hospital.
HERDMAN, MISS LILLIAN E.	Graduate Seattle General Hospital.
HEMPEL, MISS CLEO	Graduate Colorado Training School, Denver.
HUMPHREYS, MISS ALICE HOYD.	Graduate Fabiola Hospital, Oakland, Cal.
KENNEDY, MISS	Graduate St. Luke's Hospital, Duluth; Sloan Maternity, New York.
LACKORE, MISS LILLIAN	Graduate Wesley Hospital, Chicago.
LAEMMERICH, MISS LOUISA	Graduate Winona General Hospital.
LIVERMORE, MRS. AGNES B.	Graduate Minnesota Training School.
McGREGOR, MISS HATTIE	Graduate Seattle General Hospital.
NEWTON, MISS G. W.	Graduate Royal Jubilee Hospital, Victoria.
RAY, MISS JENNIE	Graduate Seattle General Hospital.
SHROEDER, MISS H. L.	Graduate Seattle General Hospital.
SLATER, MISS GRACE	Graduate Eastern Illinois Hospital.
SLATER, MISS MAME	Graduate Eastern Illinois Hospital.
SHIACH, MISS MARY	Graduate Seattle General Hospital.
STRAHL, MISS INEZ	Graduate Asbury Hospital, Minneapolis.
STRONACH, MISS MINNIE	Graduate Brompton Hospital, London.
MISS MARGARET UNDERWOOD	Graduate Buffalo General Hospital.
WAGNER, MISS IDA	Graduate Riverside Hospital, Milwaukee.
WANAMAKER, MISS NIDA	Graduate Seattle General Hospital.

NORTHWEST MEDICINE

February, 1904.

PRESIDENT'S ANNUAL ADDRESS.*

By J. P. Sweeney, M. D.,

SEATTLE, WASH.

In addressing you this evening I shall depart from the usual custom of my predecessors, of presenting a paper on some scientific subject or original investigation, and request your attention for the consideration of some few things appertaining to the practice of medicine in this locality which have come to my knowledge as your president, and which I trust will interest you.

The practice of medicine in the Northwest has been such as is usually found in new countries, the physician having to make long rides, cross mountain streams and rivers and, often unable to make the point desired, having to camp out over night. Of those who have braved the storms on Puget Sound in an open boat or canoe, and those who have had to cross the Columbia river swimming their horses behind the boat, honorable mention should be had. The first physicians arriving in this part of the country came with the first settlers, making the journey across the plains. Dr. D. S. Maynard and Dr. Joseph Williamson arrived about the same time in 1851; Dr. Maynard practiced in this vicinity for about twenty years; Dr. Williamson practiced very little, soon opened a store and attended to mercantile matters. Among the first physicians arriving here was a young man by the name of Styner, who was killed in the uprising of the Indians in 1856. Dr. Kellogg, who recently died, practiced among the people living on the islands. Dr. Robertson came to Seattle at the close of the Civil War. Dr. Chapin arrived about 1867, brought the first microscope, and performed the first operation for cancer of the breast, assisted by the surgeons aboard the U. S. Flagship, Saranac, then in the harbor. The patient then operated upon, Mrs. S. F. Coombs, is yet living in this city. After the War of the Rebellion many other physicians came here; and at the time of the great fire in this city, June 6, 1889, there were in practice about forty physicians, twenty of them doing the work. We were all incommoded by that fire, and laughable and amusing incidents occurred in the practice of medicine at that time. I erected the first tent, at the corner of Second and James. It had no floor, lumber being scarce: within it I had a table and two chairs, and a friend, who was without a home or lodging, slept in it at night. I would bring my bag of instruments, bandages, etc., in the morning, and attend to those who called. It was nothing in those days to lift the flap of the tent and call out, "Next." Our patients had to sit around on the grass outside or on such conveniences as they could obtain. Many of us had offices in tents, which were placed in better repair as the winter came on, some having to remain in them a year and a half until the buildings they desired to occupy were ready.

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*Delivered before the King County Medical Society, Seattle, Wash., Dec. 21, 1903.

Let me congratulate you on your success and progress as a medical organization. From a nucleus of twelve physicians who organized this Society August 7th, 1888, it has grown to the number of one hundred and ten active members in good standing, with three honorary. You are now the strongest and most representative body in the Northwest. During the past year you have accomplished more work than has been done in the same time since the beginning of the society. I shall not review the same, but will leave that for the Secretary's report which, when it is read, I am sure will be most pleasing to you. The attendance at the meetings has been such as to expedite the business of the society; the papers read have been of such a scientific and literary character as to engage the attention of the members, and have brought out discussion concerning their subjects in a manner that has increased our knowledge and furthered the interests of medical science in this locality. The only disagreeable feature of the meetings of the society for the year was the expulsion of one of our members. As it was the first expulsion since the organization of the society, we all felt annoyed to do that which it was necessary for us to do. Let us hope that we will not have to expel another member for at least fifteen years more, and trust that the disciplining of a member will never require such a severe measure again.

With the beginning of the year a new constitution and by-laws became effective, which enabled us to be more affiliated with the Medical Association of the State and also the American Medical Association. By reason of knowing we were working more in harmony with like societies in the State and Nation than formerly, and by reason of the clearness of the precepts of the new constitution and by-laws and the arrangement of the manner of our business, we have been able to increase our work and stimulate one another to do better.

Coincident with the adoption of the new constitution and by-laws there was founded by the Washington Medical Library Association a medical journal, called NORTHWEST MEDICINE, which has kept us fully posted as to the leading events in medical literature, and has been the means of the greatest possible benefit to the members of this society, as well as to the medical profession of the Northwest. We who depended on our Eastern and foreign journals to keep us informed regarding the progress of medical science, have, since its birth, been enabled to keep closer to the line in medical knowledge than formerly, and by reason of the publication of full reports of our meetings and of the papers presented and read, been enabled to review our work and strive to do better. Under the capable and energetic management of Drs. J. B. Eagleson and Clarence A. Smith, Editors, NORTHWEST MEDICINE has been prosperous and, having published from time to time all that was notable or worthy in medical progress, relieves me from repeating it in this, the Annual Address.

The Washington Medical Library Association, under whose auspices the publication of NORTHWEST MEDICINE is had, is composed principally of members of the King County Medical Society. A number of magazines and books have accumulated and are being cared for by various members of the Medical Library Association, and the time is drawing near when a proper place for their care and accessibility will be needed. The King County Medical Society a few meetings ago appointed a committee to see the Trustees of the City Public Library concerning a location for a medical library in the new Carnegie Public Library Building. One of the members of the Board of Trustees of the City Public Library, Dr. J. H. Lyons, is also a member of this society, and with the committee arranged a meeting with the Board of Trustees; the matter was fully discussed and it is understood that we shall have a room in the new Public Library Building for the purposes we desire.

An event of importance to us this year was the gift to this society, by Dr. A. R. Becker, of a complete working pathologic laboratory. It was placed in charge of a committee, who have so managed its affairs that it is now self-supporting. For a month or so a few of our members volunteered to maintain it, and our society paid its location rental. The committee, by reason of the courtesy of the Kennedy Drug Company, have secured quarters for the same and have it in charge of a competent pathologic director. It has proven of great use to those who have had need of its services, and will prove of much greater, stimulating our members to make researches which will advance the cause of medicine in the Northwest. Dr. A. R. Becker, the donor of the laboratory, a gentleman of mature years and of great experience, has passed his life in pathologic study, and by giving us a complete working laboratory has erected a monument to his name that will live forever, and endeared himself to the medical men of the Northwest, particularly to the members of this society, of which he has been elected an honorary member.

It is to be noticed since our last annual meeting that a greater conservatism is manifested by those doing surgery. It would be well in many cases to have more time given to prepare the patient before operation; and the physician more than the surgeon determines whether an operation should be performed or not. Many cases have proven unsuccessful as regards the life of the patient and, if more studied before the operation, the question would not be asked by the laity, "Why did they operate if they could not benefit him?" Public opinion is affected by trivialities, and as the pendulum of the clock of time has swung so far towards surgery during the last twenty years, that the laity have become fearful lest the knife be over them constantly and, like the cimeter hung by a golden thread, only awaits the cupidity of the commercial spirit to sever its strands. To such conditions as have prevailed in the medical world for a number of years, is due the starting up of so many schools of medicine and institutes of osteopathy, Christian Science and other fads. Owing to the fear of the knife on the part of the laity, and the strenuous appeal for its use by the surgeon and quite often the physician, and being overcome with dread while marvelling at the wonderful results of those who operate, they fly when sick to those who promise relief without its use. It is proper, therefore, that the physician look to the medical more than the surgical side of the question in the future, and that the surgical side be looked after entirely by those who are eminently qualified, and by no others. As surgery was developed by barbers, let us not after these many years let it revert to them and make it barbarous by allowing it to be done by those not qualified. Should we allow the laity to become imbued with the belief that the duty of the physician and surgeon in the majority of cases is to use instrumental and surgical measures, we would simply multiply and increase the number of charlatans, institutes and so-called faith cures, osteopaths, and the ever-increasing horde of designing knaves, thus lowering the tone of medicine, destroying its efficiency and injuring the public. It has become so common to hear the word "Doctor" because of these schools of charlatanism, that the following from an old writer would seem to apply:

"There is no fool, whate'er the sex or grade,
  Monk, barber, shrew, comedian or old maid,
Soap-boiler he or pompous pharmacist,
  Bath-keeper, forger or vile abortionist,
But has his name among wise Doctors placed,
  And thus through greed the healing art's disgraced."

That we have need of greater hospital facilities for the care of the sick; that we have need of a hospital for contagious diseases, and a city hospital for the care of the suddenly afflicted where the patient may at least breathe fresh, uncontaminated air, I am sure you will agree with me.

My attention has been called to the fact that a number of physicians do certain work for fraternal orders that give them but a mere pittance for attending both the members and their families. One who looked it up found that he had done a large amount of work in one month that, if the regular fees had been charged, would have netted him one thousand dollars, but by reason of his contract or appointment, he was only entitled to the small sum of $83.00. It is such conditions as these that make the physician and surgeon feel belittled and ashamed; but while the services of medical men can be obtained at the absurdly low fee that now prevails for such services, just so long will the profession not be respected and the familiar cry of "Hello, Doc," be heard.

We also have among us corporation physicians, who do a great deal of work for limited fees, sometimes only that of an annual pass over the companies' lines, whose aggressiveness in the interests of their employers has been such during the past year that some of our members have felt aggrieved. While there should be the greatest harmony between the employer and the employee, yet the courtesy due one another as physicians should be paramount. I have no specific statement to make of any particular case, but such have come to me that certainly a few remarks presented by the President at this particular time may, by calling the attention of these gentlemen to the fact of their aggressiveness, be of service.

Another evil to the public and the medical profession is the disrespect shown to the wishes of our local Board of Health; composed as it is of physicians, their opinion is well worthy of consideration by the public and the city government. Quite recently a meat inspector was to be appointed. According to the terms of the charter it became the duty of the Board of Health to appoint. While I have no knowledge, personally, as to the statements made by the City Council, yet in the public press a few evenings ago was a statement by a member of the city government that the Board of Health appointee should not receive any salary unless the person appointed was some one that the City Council was pleased with, and that if the Council were well pleased the person appointed might receive $80.00 as a monthly salary, and probably more if the person was in every way satisfactory. What does this mean? Simply that the Board of Health, whose duty it is to protect the public in all health and sanitary matters, must follow the dictates of those who hold the purse strings, and appoint to the positions they are entitled to fill in the interests of the public good, only those that may please the City Council, which may be only the best politicians instead of the best health officers, sanitary, plumbing and meat inspectors. This society has progressed in influence and in numbers, and its opinion has weight with the public. We should uphold medical officers, both local, county and state; and when we find them coerced to appoint politicians and men of no particular training where they are to be placed in charge of public health matters, we should raise our voice and protest against the same; in fact we should act as censors of the appointments to the local Board of Health, also the County Board of Health; and the State Medical Association as censors of the appointees to the State Board of Health and State Examining Board, and such other appointees as have to do with medical matters in the State; in like manner the American Medical Association those of the Nation. Our City Government has always been sparing with funds for medical matters, so much so as to permit an epidemic to occur, and the city be placed to great expense in consequence of the same. If they would leave medical matters to their Board of Health and expect them to suppress and prevent evils of that character, I have no doubt the expense would be much less as a whole and the public interests be better subserved. When the indications were that the plague would infect our shores, and this fair city and others of the state become affected, the Governor of this State sought by every means in his power to protect us, and gave authority to the State Board of Health to carry on such measures as would prevent it, and the result was most pleasing and beneficial to the public interests. Under a law passed by the last Legislature it is required that there be a health officer in every county. Quite generally the counties have taken notice of same and have appointed physicians accordingly. Between the County and the City Health Office harmony prevails and public interests are well subserved.

The American Medical Association meets in 1905, and we, by a committee, have conferred with other societies regarding their reception and entertainment on the Pacific Coast. The matter is now in the hands of a special committee of this society, and we trust that they may find a way to have the American Medical Association with us. It is only a wealthy city and rich professional men that can entertain, yet if the social entertainments are reduced to a minimum it would seem possible, owing to the hotel accommodations that Seattle affords, to have them here. We would probably not have those come who were only bent on pleasure, but you would see and be able to care for the men who work and who are looking for it, and the moulders of professional thought in this country, the discoverers, teachers, laboratory workers and practitioners.

We have progressed socially this year in many ways. No less than three receptions have been given by medical men in honor of distinguished guests or as a token of good-fellowship, and were attended by the medical fraternity in goodly numbers. Such events mark the elevation of the profession above the strife and bickering of commercialism. Ours is a fraternity that is above that of all others; other fraternities may have high ideals, we have higher: we endeavor to give peace to mankind.

The State of Washington has received during the last year a large number of medical men and women, who have come to the State from the older communities where the climate and conditions are not as pleasing as here. Most of the number after passing the State Examining Board have located in the larger cities, Seattle receiving her full share. Our society has welcomed them heartily, and they bring to us energy and wisdom. We are the better for their presence, and we wish them well. They will find the latch string outside the door. Under the new constitution and by-laws we have become large hearted, and no one that knocks at our door is turned away, provided he agrees to practice non-sectarian medicine, and is qualified in a manner that a physician should be. All who come will find that here as elsewhere, as the epigram of Timothie Kendall printed in 1577 puts it:

"Three faces the Phisition hath:
  First as an angell he
When he is sought; next when he helpes,
  A God he seems to be.
And last of all, when he hath made
  The sicke diseased well,
And asks his guerdon, then he seems
  An ougly Fiend of Hell."

Fellows, I thank you most kindly for your very careful attention to all matters that came before you. I wish to thank particularly the various committees to whom was referred the business of the society; and our worthy Secretary for his painstaking attention to his duties, thus enabling me to perform the duties of my office more easily than could be done otherwise.

Again I thank you all for the very great courtesy and respect you have shown the Chair, your official head.

ORIGINAL CONTRIBUTIONS.

PERINEAL PROSTATECTOMY.*

By Robert Telford, M. D.
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It is not my intention in the present paper to describe the various operations in vogue for removing enlarged prostates, nor to enter at any length into the symptoms or general treatment. I merely wish to describe and invite discussion upon the perineal operation, which has become so popular in Eastern surgical centres during the past few years, and to report a case I operated upon by that method.

In this, as in all operations for the removal of the prostate, the patient must be thoroughly prepared. By thoroughly, I do not refer to the ordinary routine preparation of resting, dieting, bathing, purging and antisepsis which extends over two or three days and is common to all major operations. This is all required, but much more. Cases with enlarged prostates are usually advanced in years and their malady chronic in character. The bladder is frequently infected and occasionally a severe cystitis is present. Very often the infection has found its way through the ureters to the kidneys, which also partake of the infective process. The patient's health is usually far below par and, as a rule, they are unfit to endure any serious surgical operation. In prostatectomy the preparation should extend over two or three weeks, if necessary, until the general health is raised to the maximum, the cystitis much reduced and the urine clear and aseptic. Preliminary perineal drainage should be resorted to if necessary.

On entering the hospital they should be put upon a tonic and a nutritious diet which is unirritating to the kidneys and bladder. Abundance of water should be given, two quarts a day at least, and five grains of urotropin four times a day. The bladder should be washed out with warm boracic solution twice daily and the catheter used at regular intervals; the skin thoroughly cleansed and massaged daily. Four or five electric light baths should be given to promote thorough elimination of toxins through the sudoriferous glands and to produce a healthy condition of the skin.

The patient having been thoroughly prepared and anesthetized, the operation is proceeded with as follows: The patient is placed in the lithotomy position, a sound is introduced up to the prostate and held firmly by an assistant. The index finger of the left hand is introduced into the rectum. With sound in urethra and finger in rectum, as guides, it is comparatively easy to extend incision through the superficial structures to the capsule of enlarged gland. There are four methods advocated of making external incisions.

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*Read before the British Columbia Medical Association, Victoria, B. C., October 30 and 31, 1902.

1st. The median perineal incision, which consists of a straight perpendicular section in the median line.

2nd. Zuckerkandl's semilunar incision, which extends between tuberosities of ischia, with convexity forward.

3rd. Kocher's triangular incision, which consists of two slightly curved lines drawn from tuberosities of the ischium to a point in median line, opposite membranous urethra.

4th. Senn's Y incision, which consists of an inverted capital Y, and is made by drawing two straight lines from lower end of median incision, to points midway between rectum and tuberosity of the ischium.

I believe Senn's inverted Y incision exposes the prostate to the best advantage and will be particularly appreciated in obese subjects.

The skin, subcutaneous fascia, muscles, and membranes are incised with the scalpel. The deeper dissection, which consists of separating the rectum from and laying bare the prostate, should be done with fingers or blunt instrument. All bleeding points must be carefully secured and tied, special attention being paid to the hemorroidal plexus. Pads of gauze, wrung out of hot water, will be found of service in stopping the general oozing. A clear field is imperative to perform this operation properly: besides these patients will not endure the loss of much blood. The gland must be completely exposed before attempting its enucleation. The lower flap should be held down by a large vaginal speculum and the sides of incision held back by long narrow retractors. One of the lateral lobes of prostate is now seized by a bullet forceps and pulled forcibly downwards, while a horizontal incision is made through the capsule of the other lobe. The lobe is then shelled out of its capsule by aid of the finger, except at its junction with middle lobe. The other lobe is separated in a similar manner. The two lateral lobes are now grasped by the forceps and pulled downwards while the central lobe is clipped off, together with a portion of the prostatic urethra. The finger should now be inserted into the bladder and a thorough examination made for calculi. If any are discovered, they should be removed, enlarging the incision backwards if necessary. A small rubber tube is now inserted into the bladder for drainage and brought out at one end of incision where it is stitched to skin. A rubber catheter is passed through penis into bladder and held in place by a stitch. This serves to mould the urethra and aids in washing out the bladder. The bladder and urethra should be stitched up closely around drainage tube.

Iodoform gauze is packed well against neck of bladder around the tube and allowed to drain externally. The gauze packing serves to drain the incision and prevents urine escaping except through the drainage tube. The fascia, muscles and skin are now sewn up with silk-worm gut and plenty of dressings applied.

With the catheter in the urethra and drainage tube entering by perineum, we have an excellent chance to irrigate the bladder. This should be done several times a day until healing is complete. Gauze should be removed in from 24 to 48 hours after operation and drainage tube in about six days. After the eighth day the catheter should be removed about every second day, cleansed and reinserted. This should be continued for three weeks. Five grains of urotropin should be given three times a day, until parts are in a healthy condition. The patient should be made to sit up in from two to three days after operation and be out of bed in a week or ten days. The incision will generally heal by first intention and be completely closed in from three to five weeks.

Bottini's method and the suprapubic operation have many strenuous advocates and, until the last few years, the latter was considered the safest and easiest method, but the perineal route has now had a fairly extended trial and seems likely to survive the test of time. From an anatomic standpoint, it is to be preferred. The perineal method gives dependent drainage, which is the ideal treatment for prostatic complications, and the bladder can be thoroughly irrigated with the minimum of disturbance to the patient.

Report of Case. Patient, aged 70, has had urinary trouble for past fifteen years, the chief symptoms being frequency of micturition, more marked during the night, although quite frequent during the day. Urine was passed with little force and was accompanied with some pain at neck of bladder. Urine contained abundance of pus and mucus, but no blood. For five months previous to operation was compelled to rise every half hour to relieve his bladder. This disturbance of sleep caused a marked failure in health. Examination of prostate per rectum showed it to be moderately and uniformly enlarged. Passing of catheter caused severe pain and the patient would rather submit to an operation than resort to catheter life.

He was put under treatment for twelve days before attempting an operation. During that time he was encouraged to drink large quantities of water, received four electric light baths and had skin massaged after each. Five grains of urotropin were given four times a day, bowels regulated and bladder washed three times a day with boracic solution. At the end of this time we considered him in good condition for an operation.

After the patient was anesthetized a sound was passed and stone discovered. A sound had been passed twice previously, once by myself and once by another practitioner, but without finding the stone. The operation was performed as above described, Zuckerkandl's incision being employed. After removing the prostate an incision was made through the neck of bladder posteriorly and the stone removed.

Patient made good recovery. There was no rise of temperature. Incision was completely healed in five weeks. Slight tenderness existed in the perineum for a few weeks after leaving the hospital, but this has completely disappeared. He now rises about once during the night to relieve himself, but this is more due to habit than necessity. He says a sudden step down or jolt will sometimes give him a desire to urinate, but otherwise his urinary apparatus is in perfect condition.

DISCUSSION.

Dr. Eagleson, of Seattle, spoke of the prostatic tractor, devised and used by Dr. H. H. Young, of Johns Hopkins Hospital, and of the manner in which the prostate could be drawn down so as to be very easily reached through the perineal wound. He also spoke of Dr. Young's recent work in saving the seminal vesicles by removing each lateral lobe of the prostate separately and then reaching the median lobe through the side, by delivering it into the cavity of one of the lateral lobes.

Dr. Brydone-Jack, of Vancouver, reported three interesting cases recently operated upon by Dr. Munro. He exhibited the specimens, which were removed by morcellement.

Dr. Durand, of Everett, reported a case which he had recently operated upon successfully.

Dr. Frank W. Hall, of Victoria, reported a case which had been previously treated by castration. He opened the bladder supra-pubically, and found no enlargement of the prostate, but, instead, quite a large stone in the bladder.

Dr. Jones, of Victoria, stated that he had had no experience in perineal prostatectomy, but he had operated on four cases by the supra-pubic route. He had recently had the privilege of witnessing Freyer, of London, operate by the latter method, and was much impressed by his work. Dr. Jones believes that when the prostate is hard and firmly fixed it should be left alone, as such cases are nearly always malignant.

Dr. Telford, in closing, said that he wished to emphasize the very careful preparation of the patient before operation.

RELATION BETWEEN DISEASES OF THE NOSE AND DISEASES OF THE EYES.*

By HAMILTON STILLSON, M. D.,

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There are four paths through which intranasal disturbance may cause ocular affections: (a) through the anastomosing blood vessels; (b) by way of continuity of structure; (c) through the lymphatics, and (d) by the reflex route.

Zuckerkandl first worked out the relationship existing between the vascular system of the nose and that of the eyes. Arterial anastomosis between the nose and the eyes is effected by means of the ethmoid arteries, by branches of the ophthalmic, and by collateral trunks along the lacrimo-nasal duct, which join the angular the ophthalmic, and a branch of the infraorbital. In the same way communication is established by means of the large venous trunks running from the nose to the orbital and cranial cavities, viz.. the ethmoid veins, and by the anastomosis existing in the network of veins between the lacrimal plexus and the veins of the nose, the orbit, and the face.

Ziem,[1] in 1887, was the first to call attention to the fact that disease might be conveyed along this vascular path. He described[2] four cases of limitation of the field of vision that he considered due to nasal affections. The explanation given of this interdependence is that the retinal hyperemia caused through the anastomotic connections of the vessels of the nasal mucous membranes and the ciliary plexus induces a disturbance of the intraocular circulation and functions of the retina. His brochure was quickly followed by a flood of corroborating testimony. Dr. Siemon[3] (London) reported a case in which galvano-cautery for nasal polypi was followed by ex-ophthalmos of the right eye, with Graefe's and Stelwag's symptoms. But the patient's asthma was relieved. He incidentally referred to cases on record in which intra-nasal operations had been followed by diminution or disappearance of symptoms of Graves' disease. Schmidt-Rimpler[4] reported a case of unilateral blindness following an operation for the removal of nasal polypi. Hamilton[5] in 1890, in the "Transaction of the Second Medical Congress of Australasia," gave a resume of the subject to that date and showed in a large list of cases the relationship between the eye symptoms and the diseases of the nasal cavities through the arterial, venous, and nervous supply of the nose and eyes. Much literature has since been given forth along the same lines, though it is only fair to say that some authors have sought to explain the phenomena on slightly different grounds. Winckler,[6] for instance, insisted that such cases had individual anomalies in the anastomoses: Behnheimer,[7] that there were anomalous conditions in the vessel walls in the optic nerve and retina, etc. Some of these hypotheses may be correct. Otherwise it would be difficult to explain a case[8] recorded by Dr. Lee Maidment Hurd (New York). Instant total loss of vision in the right eye followed the injection of paraffin for a nasal deformity. The injection was made an inch above the tip of the nose on the bridge. Dr. Ward A. Holden examined the patient's right eye a few minutes later and found conditions typical of embolism of the central artery of the retina. The condition remained permanent in spite of treatment. Concerning Basedow's disease, Knies[9] thinks the subsidence of the symptoms after cauterization of the nasal mucous membrane is by way of paralysis of the sympathetic.

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*Read before the King County Medical Society, Seattle Wash., October 5, 1903.

As to the transference of disease from the nose to the eyes through the continuity of structure, Kuhnt[10] in 1895 gave us the first comprehensive work on the subject. He was followed almost immediately by Schmidt-Rimpler and also by Gruenwald, who corroborated Kuhnt's observations with a large number of cases. The walls of the orbital cavity are formed in part by the walls of the accessory nasal cavities. For instance, the median wall of the orbit is formed by the lacrimal bone, by the os planum of the ethmoid and the orbital process of the palatal bone. But these form also the outer wall of the ethmoid sinus. So that an accumulation of pus in the ethmoid sinus could easily push the os planum outward, causing the bone to become necrosed and permitting pus to be liberated into the orbital cavity. Of course the lacrimo-nasal duct offers a ready viaduct for the transmission of pathogenic germs and inflammatory processes from the nose to the external surface of the eyes, causing blepharitis, conjunctivitis, corneitis, etc., which in many instances cannot be permanently cured without first curing the nasal affection. The floor of the orbit forms the roof of the antrum of Highmore. The vault of the orbit forms the floor of the frontal sinus. Moreover, the sphenoid cavity, while having a robust roof, has a rather thin lateral wall, and just where the chiasm and optic nerve bend around the sphenoid on their way to the eye, the wall of the sphenoid is usually perforated by numerous foramina for the accommodation of blood vessels. While submitting this dried specimen for your inspection I wish to submit also a picture of a dissection made by Dr. Cryer of Philadelphia (Fig. 1), showing that in the adult there is often almost complete encircling of the orbital cavity by the pneumatic accessory nasal cavities. The section was made transversely on a line with the second molar tooth.

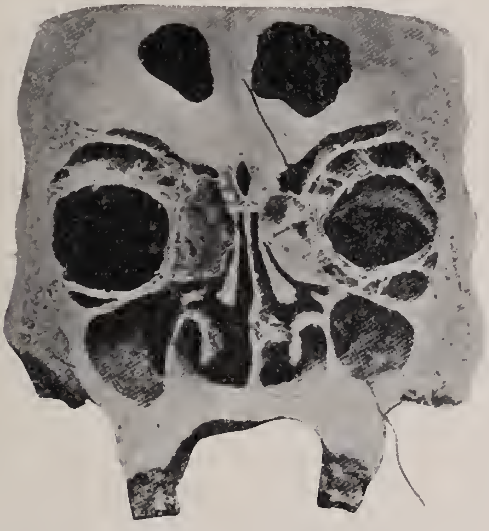

Fig. 1. Transverse section of the orbital cavity and pneumatic accessory nasal cavities, on a line with second molar tooth.

The usual way in which disease extends from the accessory pneumatic cavities of the nose to the eyes is when, in acute or chronic inflammations of the walls of these cavities, serous or purulent exudates are retained and produce bulging of the cavity walls. The bulging in the antrum of Highmore is usually toward the median line of the nose, but in the ethmoid sinus it is toward the eye through the os planum. In the frontal sinus the bulging is usually toward the eye, since the wall of the frontal fossa is quite thin. An edema at the upper end of the orbit, with rupture of pus into the orbit leading to orbital phlegmon, is the rule. Kuhnt did not investigate the sphenoid cavity extensively, but it has been worked out by others since. You can readily see that an accumulation of pus in the sphenoid might cause necrosis of the outer wall, with bulging and final phlegmon around the optic nerve just before its entrance into the orbital cavity, causing retro-bulbar optic neuritis.

In addition to the pressure symptoms caused by retention of pus, Kuhnt claimed that the absorption of purulent or fetid masses from the diseased cavities plays a greater part in the etiology of functional diseases of the eyes than does the transference of emboli, etc., through the anastomosing blood vessels as Ziem contended. As to what some of these diseases are, a brief reference to literature may be made. Caldwell[11] (New York) after emphasizing the importance of the subject and the frequency of the condition refers to a case of Eales[12] of Birmingham, of optic neuritis from ethmoid disease cured by the evacuation of pus; a case of glaucoma, by Lenox Browne,[13] cured by the removal of a nasal polypus; cases by Pagenstecher[14] of orbital cellulitis with lowered vision and contraction of the field of vision, caused by maxillary sinusitis, relieved by the extraction of a carious molar and the evacuation of pus through the alveolar process: a case of optic neuritis, by Burnett,[15] that subsided after a free flow of pus from the nose. Caldwell also referred to several cases of his own of asthenopia, retinitis, and optic neuritis relieved by attention to the nasal fossae and accessory sinuses.

As to the third path, the lymphatics, intelligent investigation began in 1890, but the extreme importance of the subject is just now beginning to be recognized. Naunyn and Schreier began by injecting warm salt solution into the subarachanoid space of the dog and observed that the solution came out at the nose. Immediately thereafter T. S. Flateau[16] quoted a case of chronic hydrocephalus that got well after an abundant serous discharge from the nose, and Schalbe, Key, and Retzius[17] demonstrated the anatomy of this intercommunication. This is somewhat of a return to the ancient view. The cribriform plate of the ethmoid bone was, of course, seen by the ancients only in the dried specimen. Not having access to wet specimens, they doubtless considered the perforations in the sieve-like bone to be permanently open, and since the ancients were ignorant of the existence of the muciparous glands they naturally inferred that all fluids coming out at the nose had sifted down through the cribriform bone from the brain. Hippocrates, Galen, and their followers, therefore, constructed an elaborate hypothesis to the effect that air and other vapors were drawn through the nose to the brain, where, acting like a huge gland, the brain redistilled these vapors, producing thought and discharging mucus. Hence sluggishness of intellect was caused by faulty excretion of mucus from the brain, the mucus simply accumulating in the brain and clogging its operations.[18] We still claim that hypertrophies in the nose will cause mental hebetude and inability to fix the mind long or logically upon any subject. But the modern explanation is that the clogging of the lymph channels by the hypertrophies interferes with the elimination of waste products resulting from cerebral activity, and that these hypertrophies also, in interfering with proper aeration of the lungs, prevents the elimination of carbon dioxide which, accumulating in the blood, causes a smothering of the cerebral powers. The name *aphroxia* has been given to this condition.

As to the eye, it is claimed that the anemias of the retina, retinal congestions, retino-choroiditis, etc., are often caused by hypertrophies in the manner explained, and that many of the cases of asthenopia, migraine ophthalmique, are cured only when the nasal affections are cured.

Concerning the reflex route, writers from Galen down have discussed it. Learned volumes have been written upon it. We will dismiss it briefly.

The claim is made that such diseases as glaucoma and exophthalmic goitre have been cured by operations on the nasal turbinates, the claim being that the path was through paralysis of the sympathetic nerve. This may possibly help to explain why operations on the face are usually attended by so much surgical shock, and also why cocainizing the nasal mucous membrane lessens the period of excitement in chloroform anesthesia. And as to ordinary reflex symptoms I cannot do better than to sum up Gruening's[19] conclusions. Removal of hypertrophies in the nose often causes cessation of the following eye symptoms:

1. Burning and smarting of the lids more pronounced in the morning.
2. Inability to "fix" an object in ordinary daylight.
3. Increased vascularity of the conjunctiva.
4. Lacrymation on slight provocation.

All these in cases where there is:

1. Sound eyes.
2. Efficiency of nasal treatment in spite of absence of nasal symptoms.

In illustration of the relationship between the nose and the eyes I wish to rehearse two cases of my own.

Case I. Blindness from operation on the nose. Mr. X., aet. 44 years, mayor of a neighboring city in Washington, presented himself in April, 1903, with the following history:

In November, 1901, caught cold: had neuralgia, with swelling in right side of face. Swelling finally broke into the nose and ran matter. In August, 1902, was operated upon at Copeland Institute. After using cocain the nose was cut inside. Just at the time of the cutting the right eye became totally blind, not being able to see even the sun. The eye remained blind for about a week. The sight then began to return at the sides. That is, when looking at the center of a sheet of paper only the outer edges could be seen.

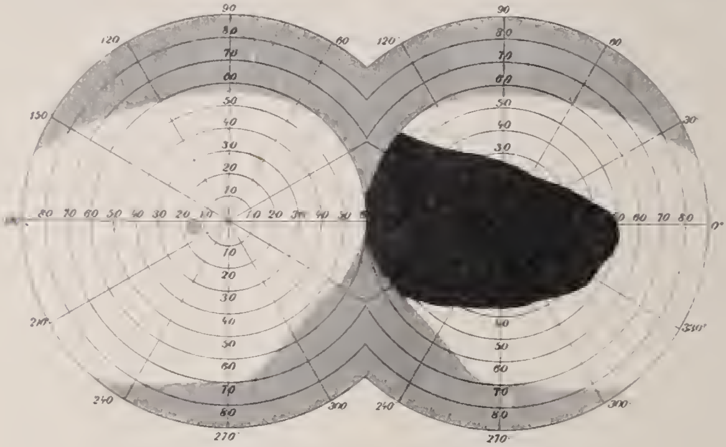

Fig. 2. Field of vision in blindness from operation on the nose.

This central dark space got smaller for about four months, but for the last four months (to April, 1903) remains stationary and fills the page about one-third.

Present condition (April, 1903) of the patient, a large well formed man of 44 in apparently good health except that the right

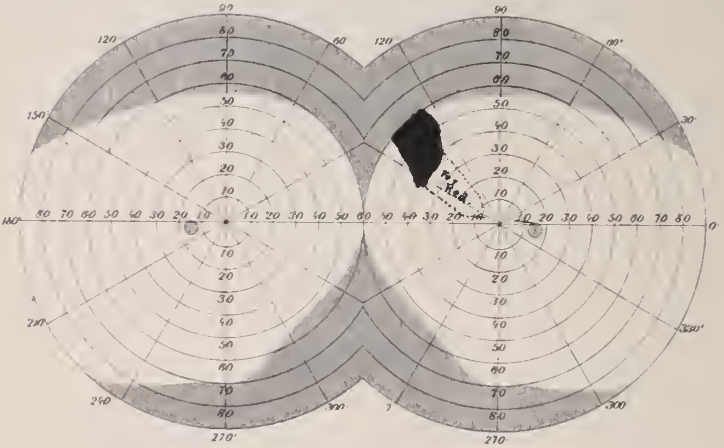

Fig. 3. Field of vision six months after injury.

side of face is swollen, especially the right upper lid, conjunctiva congested, but the only other abnormality about the eye, a paleness in the region of the macula. In the nose there is ethmoiditis, and hypertrophies of the mucous membrane over the turbinates, and a bridge of cicatricial tissue far back, extending from the posterior end of the ethmoid to the septum; pus coming from the region of the hiatus semilunaris, and by transillumination the antrum of Highmore clearly shown to be full of pus, as also the frontal sinus. The condition of the field of vision is indicated in the Fig. 2.

After reduction of the hypertrophies and thorough drainage of the accessory cavities the blind spot diminished in size until now, after six months, there is but a small scotoma near the periphera. The field is represented by Fig. 3. It is doubtful whether complete restoration of the entire field of vision can be effected, since doubtless atrophy has begun.

Case. 2. A second case is one of meningitis and death from operation on a tumor presenting in the region of the left ethmoid.

The history he gave was that three years previously a tumor had been removed from the left nostril and the place burned by some doctor in Chicago. Three months afterward eight tumors were removed by a doctor in Boston. The nostril remained open for two weeks and then closed worse than before and there was intense pain in the head, constantly, after the operation.

Status Presens: Left side of face enlarged, left eyeball protruding, inability to close lids, pupil rigid, eyeball limited in its movements, in the fundus well marked papillitis, field of vision contracted, central vision 20-100, temperature 101, pulse 110. In the left nostril a tumor filling the lumen, bleeding readily on being probed, exact dimension impossible to ascertain, but pus bathing it above and below.

My diagnosis was fibro-sarcoma, complicated with sinusitis of accessory pneumatic cavities, and orbital cellulitis, with retrobulbar optic neuritis and meningitis. His condition was so precarious that little could be hoped for, but to relieve the pus I removed the anterior portion of the ethmoid bone and that part of the tumor filling the entrance to the antrum of Highmore, and obtained a great gush of very foul smelling pus. Whether any of it came from the sphenoid or frontal sinus could not be determined, but the fear was that the orbital cellulitis came as the result of extension of pus from the sphenoid, and that the drainage from that cavity was not well maintained. There was considerable shock from the operation, but the general symptoms improved until the seventh day. On the sixth day the temperature was 99°, pulse 96, fair appetite, patient rational and reasonably free from pain, copious flow of pus. On the night of the sixth day pain arose. On the morning of the seventh day temperature 101°, pulse 110, some contraction of the facial muscles, slight involuntary evacuation from the bowels. Eighth day temperature the same, patient slightly incoherent in speech, opisthotonus marked. A collection of pus in the upper lip was evacuated. Great improvement in all the symptoms on the ninth, tenth and eleventh days, but on the twelfth day there was cessation of pus, carphalogia, opisthotonus, stertorous breathing, periods of muttering delirium, involuntary evacuations of the bowels. Death came on the seventeenth day. No autopsy.

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SHOULD IT BE A FIXED RULE ALWAYS TO USE ANTISEPTICS ON OUR HANDS?*

By E. M. Brown, M. D.

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I am prompted to make these few remarks from two motives: first, from my own work I feel safe in depending upon mechanical cleansing, as I fully believe that in many cases (in my own especially) it is safer than to use antiseptics, that often cause the hands to become irritated and so fissured, roughened and cracked that their sterilization becomes impossible and furthermore impair the useful sense of touch; secondly, by the reading of a paper, published by Dr. Edgar R. McGuire, of Buffalo, N. Y. Most that I say will be gleaned from his study of the subject.

Every surgeon wishes to do all he can to lessen the dangers of his work, and to do so should leave no part of his technic weak. At this time we well know that perhaps the weakest part of surgical technic is the sterilization of the human skin. We therefore find many pet methods of hand cleansing, and from the fact that so many methods and chemicals are used, there is a proof that none are perfect. If by careful investigation any surgeon is convinced that a method is safe, he would follow it, no matter what it might cost. But from many investigations we are led to assert that none of the methods in common use can be absolutely depended upon. Bennie says, "Scientifically clean hands cannot be obtained but every effort should be made to be as clean as possible." Kong tells us, "No method at present is known of absolutely sterilizing the hands." Many others of the same opinion depend upon gloves. During the last few years much experimental work has been done. I have many times read reports and papers that seemed to prove that certain antiseptics used in approved ways rendered the hands clean. It is not my purpose to speak of these at length, but will refer to one at least, mercuric bichlorid, as it is so often used. We well know that, on account of low cost, freedom from odor and its well-known germ-destroying powers, it is an antiseptic most useful for sterilizing many things, but, as Dr. McGuire demonstrates, and many good men believe, we have in it a substance, the use of which as a means of disinfecting the hands is not only questionable but also distinctly harmful when improperly used, and he urges that it should not be employed in sterilizing living tissues. In using mercuric bichlorid all agree that we must first, by some means, remove the outer layers of loose epidermis, fat, dirt, etc. This is done by means of hot water, soap, brush, etc., many using marble dust, mustard and meal or turpentine, according to the notion of the person. One or more of these things being done to prepare hands for the application of the mercuric solution, we then know that the germs not washed away are hidden in the small crevices of the skin and glandular structures, covered more or less by epidermal cells and in such a situation what possible benefit can accrue from using a substance which not only lacks penetrating effect but also has the property of forming an inert albuminate on the skin?

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*Read before the Washington State Medical Association, Spokane, Wash., Sept. 1, 2 and 3, 1903.

"It is evident the germs are not reached by the mercuric bichlorid, but are simply incased, as it were, by this new albuminate layer. During an operation, what takes place under these circumstances? The alkalinity of the blood and tissues neutralizes the effect of the mercuric bichlorid and, under constant manipulation, this outer albuminate layer is neutralized and removed, thereby allowing the pent up germs to escape into the wound. In culture experiments this same condition exists, only it is necessary to use ammonium sulfid instead of the blood to neutralize the meruric bichlorid. When this is done there are found equally as many growths as there were previous to use of mercuric bichlorid. As proof of this thirty experiments were made: The hands were scrubbed in running sterile water, with sterile brushes and sterile soap. Four to seven sterile brushes were used, about three minutes each. At this stage cultures on agar were made from each hand. Then the hands were immersed for five minutes in mercuric bichlorid solution, 1-1000. Next they were washed in running sterile water for one minute and finally soaked in ammonium sulfid solution. Then from the corresponding part of the hand used before, cultures were again made. On comparing results before use of antiseptics with those after its use there was seen no appreciable difference, showing the complete failure of mercuric bichlorid to render the hands any freer from living germs."

I could give the reports of other investigators leading up to the same end. "Also that what has been said with reference to mercuric bichlorid may, for the most part, be applied to the other antiseptics most often used in hand disinfection." Potassium permanganate and oxalic acid, chlorinated lime and sodium carbonate all present similar objections. First, they are unable to reach the germs in the deep layers of the skin; secondly, all are so irritating to the skin, of most people, that they defeat the very purpose for which they are intended; thirdly, they decrease the resistance of the tissues; and fourthly, the false sense of security offered by their use renders them distinctly harmful."

The operator's hands should be kept as smooth and soft as possible. If they are in this condition it will be much easier to keep them clean; in fact, many hands we well know become so rough from the frequent use of antiseptics that they are not fit for use in the operating room, as it is impossible to get them clean.

In making these remarks, showing my inclination to cease the use of chemicals on the hands, you are not to think that I omit any effort to obtain asepsis. If this can be secured by chemicals we must use them, but if chemicals do not aid us we should not use them for the reason that they injure the hands.

To my mind the most rational way to treat hands is by mechanical cleansing; first, with soap and water, changing water, brushes, etc. very often; pay strict attention to nails, spaces between fingers, etc., as well described by so many good men who are very careful in this, even if trusting to chemicals. Then, after careful use of soap and water, I would advise submersion for five to ten minutes in water as hot as can be conveniently borne, this to produce dilation of the capillary vessels and excite the secretion of the skin glands, in this way lessening subsequent secretion during operation. I would not use any thing after this unless alcohol. And this I do not use as a germicide, but rather for the hardening effect upon the skin. If, after the careful washing with or without chemicals, there are still germs on the hands that cannot be removed, the use of alcohol by its action may, as it might be said, lock them in by its hardening effect. During long operations dip or wash the hands in hot water and again use alcohol.

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VOL. II. FEBRUARY, 1904. NO. 2

THE AMERICAN MEDICAL ASSOCIATION AT PORTLAND IN 1905.

It is considered a distinction and honor for any city of our land to entertain so large and distinguished a body of men as compose the American Medical Association. Provided the cities of different sections, therefore, can furnish the requirements of such a meeting it is to the interests of the whole medical profession that, periodically, the Association should favor with its presence as many parts of our nation as possible. A large and powerful body of physicians is found on the Pacific Coast which feels it is entitled occasionally to the annual meeting. It is more than ten years since the Association held its last meeting on the Pacific, at San Francisco, and the belief exists that we can now justly present our claims and put forth our best efforts for another.

We recognize that, by reason of the long journey and expense of the trip to the Coast, a request could not be made at this time unless special circumstances favored it. These conditions are presented in the Lewis and Clark Fair to be held at Portland in the summer of 1905. This celebrates an epoch in our national history when a vast domain was added to our territory, second only to that of the Louisiana purchase. It is, therefore, an event of such historical interest as to attract visitors from all parts of the East. The people of Washington have a special interest in this fair since their state formed a portion of the territory under consideration. It will probably be many years before railroad rates will be available at so low a figure as at this time. These facts, as we understand it, instigated the plan of inviting the American Medical Association to meet on the Coast in 1905.

After a preliminary discussion, the Washington physicians were informed that, owing to the anticipated crowded condition of the city at that time, the Portland physicians hesitated about undertaking the meeting. When the matter was brought before the King County Medical Society it entered with enthusiasm into the suggestion of bringing the meeting to Seattle and preliminary steps to that end were taken. Hotel accommodations and assembly halls exist of a sufficient capacity to meet the demands of such an assembly and the committee, appointed to investigate the plan, reported it could be handled without difficulty. The delegation attending the meeting of the Oregon State Medical Association was instructed to offer the support of the Seattle profession, in case an effort should be made to hold the meeting in Portland, but, if the Portland Society did not care to work for it, the King County Society would put forth every effort to secure it and would solicit the assistance of the Portland brethren. In course of time it was announced that the Portland City and County Society would endeavor to have the meeting held in their city in 1905. Therefore the physicians of Seattle will hereafter exert their influence, in every possible manner, to assist the Portland profession in obtaining this valuable convention.

Northwest Medicine wishes to express its hearty endorsement of this move. We believe the meeting, if secured, will be one of pleasure and satisfaction to Eastern visitors and of profit to the profession of the Northwest. We shall expect a goodly number of visitors to return to their homes by way of the Sound cities and many will doubtless take the opportunity of making the incomparable summer trip to Alaska. Their entertainment will not cease at Portland, but a welcome will be continued at Seattle and Tacoma. We trust Portland will present the matter before the House of Delegates in such a manner that they will be persuaded to select this city for 1905. The whole Northwest will then assist in making this a memorable meeting of the Association.

WHY IS SCARLET FEVER EPIDEMIC IN OUR CITIES?

That scarlet fever has prevailed to an unusual extent in many of our cities, during recent months, is evidenced by the monthly health reports. During the past year 413 cases were quarantined in Seattle, the record showing a steady monthly increase during the later months. Last month seventy-seven cases were reported. The mild character of the disease is witnessed by the record of only twelve deaths for the year, some of these, however, being of a malignant nature and of but a few days' duration. Unquestionably many mild cases existed, the report of which did not reach the health office.

Knowing the readiness with which the disease is communicated to children and the serious sequelæ of a temporary or permanent nature that so commonly accompany it, the most strenuous measures should be enforced to check its extension and, if possible, obliterate it from the community.

Doubtless it is true elsewhere as in Seattle, that its presence is fostered chiefly by two factors, the ignorance of the laity as to the dangers of a slight attack and the indifference or gross carelessness of certain of the medical profession in reporting and quarantining mild cases. The public will never be alive to the serious nature of the disease till it realizes that a child with a slight sore throat and a two days' rash can produce a fatal case in the family living next door. How long shall the delusion be permitted to exist that such a case is a simple scarlatina and hence different from scarlet fever? It is our duty at all times to proclaim the terms synonymous and interchangeable. Then we may see fewer children, in the period of desquamation, at play with their fellows. At the opening of the present school year a careful examination at the Seattle public schools disclosed more than a dozen children applying for admission, in a vigorous state of desquamation. Since then others have been discovered from time to time.

However we may deplore such ignorance on the part of the laity, the indifference with which these mild cases are viewed by some physicians is nothing but criminal. Last month a man informed the Seattle Health Officer that his boy had recently had a mild attack of scarlet fever, but the doctor had broken it up and he was cured in three days. Investigation showed the boy at school, actively desquamating, and in a few days eight other cases appeared, directly traceable to this. At times the inconvenience of quarantine measures, the stigma caused by publicity and the promise carefully to observe all necessary precautions are presented to the attending physician to induce him to conceal a certain case. But, in the interest of the citizens as a whole, the individual case should be known and duly proclaimed.

The responsibility for this condition rests primarily with the medical profession, upon whom devolves the duty of instructing the public in medical matters as well as attending to its ills.

MEDICAL NOTES.

Annual Meeting of Washington Medical Library Association.—The meeting was held January 12, at which time reports for the year were presented. The whole activity of the Association has been devoted to the support of NORTHWEST MEDICINE. The treasurer's report showed a satisfactory condition, the journal being in a flourishing state, with assets in excess of liabilities. The following trustees were elected for the ensuing year: C. W. Sharples, F. H. Coe, E. E. Heg and H. M. Read, of Seattle; E. M. Brown, of Tacoma.

The meeting of the trustees was held January 18, when C. W. Sharples was elected President of the Association; H. M. Read, Secretary; J. B. Eagleson, Treasurer. C. A. Smith was elected Editor-in-Chief, and J. B. Eagleson, Managing Editor, of NORTHWEST MEDICINE.

The Medical Library.—It was voted to proceed at once with the collection of books and pamphlets for the library. Hitherto this work has been delayed, pending the erection of the Seattle Public Library, in which space will be allotted for this. It is not intended, for the present, to plan for an actual working library and reading room, but material will be collected and classified, preparatory for daily use when conditions are favorable. Physicians have been requested to communicate with the Library Association if they have books and files of journals which they desire to contribute to the library, and they will be duly collected. The greatest importance is attached to the journal files, as practically containing everything in medicine, and an effort will be made to make these as complete as possible. Physicians outside of the city, who are willing thus to contribute, are invited to write the list of books and journals at their disposal, in order that a selection may be made to complete volumes and unnecessary duplication be avoided.

The Washington State Board of Health.—The annual meeting of the Board was held at Olympia, January 15. The following officers were re-elected for the ensuing year: President, S. B. Nelson, of Pullman; Secretary, E. E. Heg, of Seattle.

The general condition of health in the state was reported good. Only one outbreak of disease has occurred that might be termed epidemic, that of typhoid at North Yakima. An energetic investigation was made by members of the Board, and certain recommendations made for checking the disease and preventing the recurrence. A subsequent dimunition of the epidemic proved these measures effectual.

The establishment of County Health Officers to attend to contagious diseases outside of cities of the first class has progressed satisfactorily. Thirty-four counties have thus complied with the law, leaving but two without such an officer. The omission is excusable on the part of one of these, whose Board of County Commissioners states that there is no practising physician in the county and asks for further instructions.

Examination of Undertakers.—The second annual examination was held by the State Board of Health, in Seattle, January 16. Twelve out of eighteen applicants were successful. They are supposed to have some knowledge of anatomy, but are chiefly examined on the subjects of disinfection and contagion; also on the rules and regulations of the State Board. A license thus obtained is considered a guarantee of its holder's efficiency in preparing a body for shipment. The railroads will transport bodies whose death is caused by any contagious disease, except small pox, provided it has been prepared by an undertaker, licensed by this state examination. This custom prevails throughout the land, and nearly all the states now require such a license from embalmers and undertakers.

Officers of Whatcom County Society for 1904.—At the annual meeting of this society, held January 11, the following officers were elected: President, D. E. Biggs; Vice-President, Frank J. Vankirk; Secretary, Wilbur N. Hunt; Treasurer, H. Thompson.

CORRESPONDENCE.

FROM THE STATE MEDICAL EXAMINING BOARD.

Tacoma, Wash., Feb. 1, 1904.

To the Editor:

You will please give publicity to the following statement, through the pages of Northwest Medicine:

Medical examinations in the state of Washington are held only on the first Tuesday, Wednesday and Thursday of January and July, the January meeting being held in one of the cities west of the Cascade mountains, and the July meeting in Eastern Washington, at Spokane. No special certificates will be issued, and hereafter, expecting that this general notice will reach all practitioners and medical students, persons coming here between examinations must not expect to practice without molestation, for we find that the majority of those who have insisted on so doing and who requested immunity, have been found deficient. It adds to their chagrin and complicates unnecessarily the administration of the medical law. No reciprocity exists between this and other states. There is no recognition of certificates from any source.

Exchanges please copy. Medical schools please post as a standing bulletin.

P. B. Swearingen, M. D.,
Secretary State Medical Examining Board.

QUESTIONS PRESENTED BY THE WASHINGTON STATE MEDICAL EXAMINING BOARD.

Tacoma, January 5, 6, 7, 1904.

ANATOMY.

Dr. E. E. Shaw,
Walla Walla, Wash.

1. Name cranial nerves and give distribution of fifth pair.
2. Describe knee joint and name muscles which flex it.
3. Name muscles which rotate arm.
4. Name structures which pass through the diaphragm.
5. Give distribution of median nerve.
6. Give nerve supply of stomach.
7. Give contents of popliteal space.
8. Give motor and sensory nerve supply of the eye.
9. Give relations and gross anatomy of the kidneys.
10. Name and describe the valves of the heart.

PHYSIOLOGY.

Dr. A. E. Stuht,
Colfax, Wash.

1. Of what elements is the blood composed? Describe each.
2. Name the digestive ferments and action of same.
3. Describe the functions of nerve fibers and nerve centers.
4. What is the physiology of reflex action and the tissues concerned in its production?
5. What is the function of the kidney and name five substances excreted.
6. What are the functions of the lymphatic system?
7. Describe metabolism as applied to physiology.
8. Give functions of vagus nerve.
9. Composition of bile and its function.
10. What are the functions of the spinal cord?

CHEMISTRY.

Dr. G. W. Overmeyer,
South Bend, Wash.

1. Define a base and an acid.
2. Name four alkaline earth metals.
3. What is a chemical equation and give an example.

4. What is oxidation?
5. Test for arsenic?
6. What is specific gravity?
7. What is the formula for sulphuric acid; for sulphurous acid?
8. Upon what property of potassium permanganate depends its value as an index of purities of air and water?
9. What chemicals are used in Fehling's test for sugar and upon what does the reaction depend?
10. Give in detail the test for bile in urine.

MATERIA MEDICA.

Dr. H. A. Wright.
Wilbur, Wash.

1. What is the physiologic action of camphor? Name three preparations and doses of each.
2. What are the oleates? Name three.
3. Define tinctures, cerates, elixirs, extracts and resins, and name two of each.
4. What is the physiologic action of potassium? Name three preparations and their doses.
5. What is the physiologic action of opium? Name three preparations and give their doses.
6. Compare the action of aloes, jalap, podophyllum and calomel.
7. What is the source of adrenilin chloride, its dose, physiologic action and therapeutic application?
8. Define hypnotics. Name and give their doses.
9. Name three caridac stimulants and discuss the physiologic action and therapy of one.
10. What are the maximum hypodermic doses, for an adult, of strychnin sulphate; morphin sulphate; digitalin; atropin and nitroglycerin?

HISTOLOGY.

Dr. C. E. Grove,
Spokane, Wash.

1. Describe the difference between striated and non-striated muscle and name three organs in which each kind is found.
2. Draw a cross section of the spinal cord showing relative positions of white and grey matter.
3. Describe a cross section of nerve fibre.
4. Describe the histology of Pyer's patches.
5. Describe the histologic structures of the uterus.
6. Describe a cross section of the skin.
7. What is the difference in the structure of the mucous and peptic glands of the stomach?
8. Tell how the plasma passes from the capillaries into the lymph vessels.

PRACTICE OF MEDICINE.

Dr. P. B. Swearingen,
Tacoma, Wash.

1. Give the pathology and etiology of fibroid phthisis and acute broncho-pneumonia.
2. Give the course, duration and mode of termination of the latter in a case that ends in recovery.
3. Give the differential diagnosis between icterus arising from an obstruction of a bile duct and progressive pernicious anemia. Give the pathology of the blood in the latter disease.
4. Give the diagnosis, course and duration of chronic interstitial nephritis. In what class of subjects is it most frequently met?
5. Where would you auscultate for the aortic and mitral valves? State the direction the murmur is transmitted in each.
6. Give the diagnosis and prognosis of an aortic regurgitation. In what class of subjects is it most frequently met?
7. What methods would you employ to differentiate between chronic gastritis and carcinoma of the stomach?
8. Name the stages of serous pleuritis. Give the physical signs of each.
9. Outline the normal liver. Give diagnosis and physical signs of the first and second stages of chronic cirrhosis.
10. Discuss acute malaria under the following heads: (a) Origin. (b) Diagnosis. (c) Types. (d) Prevention. (e) Treatment.

DISEASES OF THE NERVOUS SYSTEM.

Dr. Sharples.
Seattle, Wash.

1. Give the differential diagnosis between locomotor ataxia and spastic paraplegia.
2. Give the most frequent complication of chorea and the treatment of the disease.
3. Describe the difference between epileptic and hysterical convulsions.
4. Describe Jacksonian epilepsy and its diagnostic importance.
5. Describe hemiplegia, monoplegia, paraplegia and state the respective location of the lesions.
6. Describe an attack of hemiplegia due to an embolism from a cardiac vegetation.

7. State the condition of the patella reflex in hysteria, locomotor ataxia, spastic paraplegia and neurasthenia.
8. What are the three most prominent symptoms or evidences of cerebral tumor?
9. What is "petit mal," and describe an attack?
10. Of what condition resembling a disease of the nervous system may phimosis be the cause?

DISEASES OF THE EYE AND EAR.

Dr. Sharples,
Seattle, Wash.

1. (a) Describe phlyctenular keratitis. (b) Give the appropriate treatment.
2. (a) The instillation of what drug is indicated in peripheral ulcers of the cornea? (b) The instillation of what drug should always be used in iritis? (c) The instillation of what drug is contraindicated in glaucoma, and why?
3. What are the principal causes of iritis?
4. How do you make a diagnosis between iritis and conjunctivitis?
5. What is the treatment of gonorrheal opthalmia?
6. What ear disease is a common complication of scarlet fever, and what is the course and treatment of the same?
7. What complication of middle ear disease is most frequently seen, and what is its treatment?
8. What is the treatment of chronic suppurative otitis media?
9. What means would you adopt for the removal of a living or dead insect from the auditory canal?
10. What is the treatment of ordinary earache of childhood?

ECLECTIC MATERIA MEDICA.

Dr. G. W. Overmeyer,
South Bend, Wash.

1. Define a true stimulant. Classify and name five of each.
2. Is alcohol a food or a stimulant? If so, give reason.
3. What is a poison? How determined? Classify as to effect on tissues.
4. Name four vegetable antiseptics.
5. What is eclecticism?
6. What do you understand by the term fever? How produced?
7. What is disease?
8. What medical agents would you employ in an ordinary case of typhoid fever?
9. Name five vegetable antispasmodics.
10. Why do vegetable remedies give better results than mineral?

MEDICAL JURISPRUDENCE.

Dr. H. A. Wright,
Wilbur, Wash.

1. Define expert testimony; privileged communications, and dying declarations.
2. What is positive sign that hanging took place before death? Describe the postmortem difference in suicidal and homicidal hanging.
3. What are the most important proofs that a child was born alive, and what changes, if any, occur in the ear soon after birth?
4. Upon what postmortem evidence would you form an opinion that death was due to drowning?
5. What is the difference between intrauterine maceration and putrefaction of the fetus?

PREVENTATIVE MEDICINE.

Dr. J. M. P. Chalmers,
Vancouver, Wash.

1. State the incubative period of smallpox, scarlet fever and diphtheria.
2. State the time when the above diseases are most contagious and reasons for the same.
3. Name four of the principal disinfectants and describe their methods of use.
4. What amount of formalin or formaldehyde is required to disinfect 1,000 cubic feet of space?
5. Under what condition is formaldehyde most effective?
6. What are the most frequent sources of infection in typhoid fever?
7. What are the modes of infection in malaria and yellow fever?
8. Describe the modern methods of quarantine.
9. How would you render milk and water sterile?
10. Name the immunizing agents and give their methods of use.

HOMEOPATHIC MATERIA MEDICA.

Dr. C. E. Grove,
Spokane, Wash.

1. What is a polycrest? Name five.
2. Give respiratory symptoms of phosphorus.
3. Describe characteristic expectoration of kali bichromicum.
4. What are the mental symptoms of lilium tigrinum?
5. For what class of cases do you think of ledum palustre?
6. Mention chief indications for mezerium.
7. Give five sepia characteristics.

8. Describe a case of croup requiring spongia.
9. Differentiate between bryonia and rhus tox in rheumatism.
10. What is the chief keynote for china?

SURGERY.

Dr. F. H. Coe,
Seattle, Wash.

1. What are the conditions giving rise to pain located in the right inferior quadrant of the abdomen?
2. Diagnose strangulated hernia and describe operation for its relief.
3. Initial symptoms and diagnosis of cancer of the tongue.
4. Tabulate differential diagnosis between three varieties of shoulder dislocation and methods of reduction of each.
5. Describe a compound fracture and its treatment in full.
6. Describe what is, in your opinion, the best treatment for a sprained ankle.
7. Under what conditions would you recommend skin grafting? (a) Preparation of patient and surfaces. (b) Preparation of area from which grafts are to be taken. (c) Method of removal and application of grafts. (d) Dressings.
8. Tracheotomy: (a) General indications for operation. (b) Peremptory indications for operation. (c) How performed.
9. Anesthesia: Write an essay briefly under the following heads: (a) Anesthetizer. (b) Examination and preparation of patient. (c) General anesthetic, choice of. (d) Inhaler and method of giving each kind of anesthetic (e) Signs of complete anesthesia. (f) Symptoms of danger. (g) Methods of resuscitation. (h) Causes and symptoms of collapse. Preparation and administration of normal saline solution.

OBSTETRICS.

Dr A. E. Stuht,
Colfax, Wash.

1. What are normal diameters of the pelvis at the superior strait?
2. Under what conditions would you use the forceps?
3. Give a concise statement of the stages and management of the normal antepartum, parturient, and the puerperium.
4. How would you manage a case of breach presentation?
5. What is version? How and when would you perform same?
6. Under what conditions is craniotomy justified?
7. How would you manage a case of postpartum hemorrhage?
8. Cause of asphyxia neonatorium. Give methods of treating same.
9. Differential diagnosis between pregnancy and pelvic tumors.
10. What are the symptoms of puerperal sepsis? Give its treatment.

DISEASES OF CHILDREN.

Dr. E. E. Shaw,
Walla Walla, Wash.

1. Differentiate pertussis from bronchial cough.
2. Give symptoms, course and treatment of adenoids.
3. Describe the course of an ordinary case of measles.
4. What diet would you prescribe in a case of ilio-colitis in a bottle-fed baby?
5. Differentiate tuberculosis of hip joint from rheumatism.
6. Differentiate spasmodic laryngitis from laryngeal diphtheria.
7. Give symptoms, course and treatment of infantile tetanus.
8. Differentiate tubercular from other forms of meningitis.
9. How would you treat eczema capitis in a child?
10. Give diagnosis and treatment of aphthous stomatitis.

DISEASES OF WOMEN.

Dr. F. H. Coe,
Seattle, Wash.

1. Differentiate diagnosis between benign and malignant neoplasms of the breast.
2. Diagnose early malignant disease of the cervix.
3. Symptoms and treatment of urethral caruncle.
4. Diagnosis and treatment of extra-uterine pregnancy.
5. Diagnosis and treatment of salpingitis.
6. Thoroughly discuss diagnosis of cervial laceration.
   (5 and 8 are purposely left without limitations.)
7. Discuss results of untreated extensive laceration of cervix.
8. Discuss the results following neglected extensive lacerations of perineum.
9. State briefly how you would conduct a pelvic examination, and of what organs and structures you would note the condition.

REPORTS OF SOCIETY MEETINGS.

KING COUNTY MEDICAL SOCIETY.

President, J. P. Sweeney, M. D.; Secretary, Carl Hoffman, M. D.

The first regular semi-monthly meeting of the King County Medical Society was held at The Washington Hotel, on the evening of January 4, 1904, President Sweeney being in the chair.

Officers for the ensuing year were elected as follows: President, E. E. Heg; Vice-President, I. N. Harrison; Secretary, Carl Hoffman; Treasurer, F. M. Carroll. President-elect Heg assumed the chair.

The report of the Treasurer for the past year was presented by James Shannon.

Dr. Holmes, appointed at the last meeting to audit the Secretary's report, asked for more time to complete his report. He took occasion to criticize the custom of delegating to the Secretary the power to pay bills without an order on the Treasurer, and described the resulting confusion.

On motion of Dr. Eagleson, the President was instructed to appoint a standing Auditing Committee of three members.

The meeting adjourned to the banquet room, where the sixty members and guests sat at the annual banquet.

The second semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce, on the evening of January 18, 1904, President Heg being in the chair. Twenty-five members and visitors were present.

Dr. Holmes presented a final report as auditor of the Secretary's annual report. The banquet committee also gave a report.

The President announced the appointment of the following:

COMMITTEES FOR 1904.

Program and Scientific Work.

Carl Hoffman.
C. A. Smith.
C. W. Sharples.
C. B. Ford.

Auditing.

Alfred Raymond.
H. M. Read.
W. A. Shannon.

Ethics and Admission.

J. H. Lyons.
Ivar Janson.
G. H. Randall.
C. H. Thomson.
G. A. Tripp.

Public Health and Legislation.

J. B. Loughary.
J. B. Eagleson.
P. W. Willis.

Laboratory.

S. J. Holmes.
J. P. Sweeney.
Kenelm Winslow.

PATHOLOGIC SPECIMENS.

Acute Hemorrhagic Pancreatitis.—Dr. Sharples presented a pancreas showing this condition, with the following history:

Japanese boy, age thirty-eight, with a very indifferent history, though it was said by the Japanese physician, who accompanied him, that seven years ago he had had a severe attack of pains through the upper part of the abdomen. This attack came on Sunday night, January 10, and was extremely severe, and administration of rather large doses of opiates by the mouth failing to give him any relief. He suffered all night and all the next day. When I saw him, about five o'clock Monday evening, his pulse was 120, his temperature 96, respirations shallow. He complained of a great deal of pain and tenderness in the upper gastric region, chiefly around the umbilicus, with some tenderness upon pressure. There was a great deal of distension of the abdomen, and it was tympanitic upon percussion. He said he raised a great deal of gas from his stomach and also that he had not passed any gas by the bowels since he had been first taken with the attack of pain.

I called a consultation, at which time his pulse was 140, and we both agreed that there was an intestinal obstruction and the only thing to be done was to operate upon him, which we proceeded to do about eight o'clock that night. On opening the abdomen, below the umbilicus, the omentum was found to be adherent to the parietal peritoneum. There was quite a large quantity of blood stained serum in the abdomen. A knuckle of intestines being brought up, it was thought that the point of constriction had been discovered, for a part of the intestine was about the size of a lead pencil and had a sensation as of a fibrous cord, for a space of about three inches, on either side of which the intestine was about the normal size, with almost a square shoulder at the point of junction. Other coils of intestines being brought up, numerous such spaces were discovered, and upon exploration the omentum seemed to be adherent entirely across the upper part of the abdomen and to have been turned half over upon itself, where it came off from the transverse colon. At this point there was a decided constriction or rather flexure in the colon that obstructed its caliber.

The boy died in less than twenty-four hours. An autopsy was made, at which time the pancreas was found to be very large—three times its natural size—quite hard, and a large area was hemorrhagic. The right kidney was more congested than it should have been. It strikes me that the sequence of events was probably the obstruction of the bowels and then hemorrhagic pancreatitis. I should have mentioned before, that before his death his bowels moved quite freely. No gall stones were discovered.

Raynaud's Disease.—Dr. Sharples further continued as follows: The medical profession, as well as those working in other professions, often times have occasion to remark that certain things appear before them in parts and especially so does this seem to occur with unusual cases. You will remember that, a few weeks ago, I reported to this Society a case of Raynaud's disease, it being the first and only case of the kind that I had seen. About the middle of January I was telephoned to go to see a man east of the mountains, who had some peculiar nervous disease, associated with gangrene of the foot. Briefly I found this history: About a month ago he was lifting and had the sensation of something giving way, in his left calf, followed by numbness in his toes and foot. Paleness of the skin ensued, followed in turn by a blueness and gangrene, being, so far as I could see, another typical case of Raynaud's disease. This case will be reported in full by the attending physician.

Paralysis Agitans.—Early in January there came to see me a man, thirty-three years old, suffering from paralysis agitans. This had not been severe until about a month ago, when it affected chiefly one arm and now it has become more general. He has a brother, a year or so older than he is, who has had the same condition for about the same length of time. He also has a half-sister who is an epileptic. I mention these cases simply from the fact that paralysis agitans is usually a disease of later life, rarely developing before between forty and fifty, more than one case rarely being seen in the same family, and the usual absence of any nervous family history of any kind being associated with the disease.

PAPER AND DISCUSSSION.

Electric Burns.—Dr. E. R. Edson read this paper. He gave a description of the different kinds of electric currents, illustrated by suitable diagrams, and their effect on the human system. He described several cases of this class of accident that had come under his observation, giving the nature of their injuries, treatment and final results. He gave an interesting review of the literature of the subject.

Dr. Willis said that the essayist had given a full and satisfactory description of this comparatively new subject. It is difficult to say what strength of electric current will cause death. Some have come in contact with even 30,000 volts without being killed, though all of it could not have passed through the body. We should be careful in making a prognosis. The doctor said he never makes one now. Burns from flash lights generally recover quickly. At first the patient may have only a small spot of injury, but later the whole surface of an arm or leg may slough out. He once had a case of small burn on the hand and arm, both of which proved very serious. At another time a man came in contact with 30,000 volts, producing extensive burns of the head that caused death in a few days. The superintendent went to his assistance and, though severely injured, recovered. He had extensive sloughs over fibula and tibia from small contact. The current had gone through the nails of the shoes, causing the skin to peel off the heels. In another case a burned spot the size of a dime sloughed out to the size of one's fist. He would not agree with the advice of the writer to attempt to save a man by pulling on his coat tail. If the garment were wet, there might be two dead men instead of one.

Dr. Miles observed a number of these burns at the Monte Cristo mines, usually of a superficial nature. He stated that, in electrocution, the muscle fibres of the heart were shattered.

WHITMAN COUNTY MEDICAL SOCIETY.

President, W. N. Divine, M. D.; Secretary, R. J. Skaife, M. D.

The Whitman County Medical Society held its first quarterly meeting of the new year at Pullman, Wash., on January 18, Dr. W. N. Divine, of Elberton, president, and Dr. R. J. Skaife, of Colfax, secretary, in their respective chairs.

After the transaction of ordinary routine business, Drs. E. T. Hein, of Palouse, and C. H. Russell, of Pullman, were elected to membership.

The meeting was held in Dr. G. B. Wilson's splendid parlors and was followed by a banquet at the Palace Hotel. Those present were: Drs. G. B. Wilson, Ed Maguire, H. W. Hall and Alice A. Benton, of Pullman; Wilson Johnston, A. E. Stuht, T. D. Ferguson, W. E. White and R. J. Skaife, of Colfax; W. E. Gaines, of Oakesdale; Walter Farnham and E. T. Hein, of Palouse; Charles James, of Tekoa; W. N. Divine, of Elberton; Libby and Armstrong, of Spokane; Smith, of Latah; Nelson and others of the W. A. C. faculty.

The ladies who made corners in the game of "Pit" during the fore part of the evening and later enjoyed the pleasures of the banquet, were: Mrs. Dr. James and sister, Mrs. Dr. Smith, Mrs. Dr. Hall, Mrs. Dr. Wilson, Mrs. Dr. Maguire, Mrs. Dr. Nelson and Mrs. Dr. Skaife.

PAPERS AND DISCUSSIONS.

Symposium on Scarlet Fever—

1. Etiology and Symptoms, by Walter Farnham.
2. Pathology and Sequelae, by W. E. White.
3. Treatment, by R. J. Skaife.

Between the readings of papers 1 and 2 Dr. Johnston, of Colfax, said that he wanted every member present to answer the following questions during discussions:

1. On what day of the disease does the eruption, in severe cases, appear?
2. What was the age of your patients in whom dropsy or anasarca was a symptom?
3. On what day of the disease did the albuminuria, if any, appear?
4. On what day of the disease did you first observe the "strawberry tongue?"

Dr. Ferguson, of Colfax, commenced the discussion of the papers by saying that scarlet fever has a greater variety of symptoms than any other disease. In his cases the eruption usually appears about the 30th hour from onset of the disease. He very much doubts the strawberry tongue being a pathognomonic symptom of the disease. It cannot be seen until the coating comes off the tongue, which is usually on the third day. He called attention to the yellowish line that can be made on the skin by drawing the finger over it.

Dr. Johnston, of Colfax, said he thinks there is no pathology peculiar to scarlet fever. The pathology is the same as that of any other exanthema. It is in the complications that there is a pathology, but we cannot tell whether scarlet fever or some other disease was the cause of it. In a fatal case streptococci are always found, but other cocci are also present. In scarlet fever streptococci are always found in the malpighian bodies and in the tubules, but they are also found in these situations in the other exanthemata. Dropsy is usually the first complication noticed, but it is not always due to kidney involvement. He had one patient, 16 years old, in whom dropsy was a prominent symptom—the only case he ever saw in which dropsy occurred at that age. He never saw albuminuria until desquamation was beginning.

Twelve and one-half per cent. of all cases of otitis media are due to scarlet fever, and about the same per cent. of deafmutism is due to the same cause. Mastoid disease has occurred as late as one year after scarlet fever, but I doubt scarlet fever as the cause. Endocarditis and pericarditis are more frequently complications than is generally supposed. Patients should always be warned of danger in this direction. Endarteritis of the left popliteal artery is not rare and is prone to result in gangrene.

As to treatment of mild cases, fatality may be due to officiousness of the doctor. High enema—one pint to three gallons—gives good results when nephritis appears. Thinks acetozone ought to be good in this disease. Discharges from nose and throat are irritating—so are those from bowels. Acetozone sprayed into nose and throat, taken in water into stomach and injected high into bowel would be good practice.

Dr. Armstrong, of Spokane, said he could recall one epidemic of scarlet fever, in all the cases of which the rash was delayed—and all were fatal.

Dr. James, of Tekoa, said: The oldest patient in whom I saw dropsy was twelve years of age. I have not noticed how early albuminuria appears, I think usually on the second or third day. As to the eruption, the disease was fatal in those cases in which it was delayed.

Dr. Gaines, of Oakesdale, asked if desquamation occurs in every case of scarlet fever. He has had a case with all the symptoms of scarlet fever excepting the desquamation, and is not sure of his diagnosis.

Dr. Farnham, of Palouse, said: I think that the strawberry tongue is pathognomonic of scarlet fever, but I do not know on what day of the disease it may first be observed, because, like all other signs and symptoms, it varies. The so-called strawberry tongue of indigestion, etc., is not a true strawberry tongue.

Dr. Ferguson spoke again, saying that he thinks there is always a strawberry tongue in scarlet fever, and that it can be identified on the third day. The eruption comes earlier than in any other disease.

Dr. Libby, of Spokane, said: "I do not think that the strawberry tongue can be depended on for an early diagnosis. Desquamation occurs in every case of scarlet fever excepting in those cases where death occurs before the eruption comes out. As to acetozone, I find trouble in getting the patient to take enough of it.

Dr. Maguire, of Pullman, said the worst cases he has had were those in which the eruption was delayed to the fourth or fifth day.

Dr. Hall, of Pullman, cited a case in which there was no strawberry tongue and no desquamation. The other symptoms were those of a typical case of scarlet fever, especially the bright scarlet eruption. What was it?

Dr. Smith, of Latah, said: I have been astonished at the amount of desquamation in cases where the eruption was very slight.

Dr. Stuht, of Colfax, said: I never make a diagnosis on one symptom alone, but consider the history of the case and the symptoms, as a whole. Amount of albumin varies very much. One reason why nephritis occurs in mild cases is because they are not so closely watched as the severe ones. All cases desquamate. A mild case may desquamate more than a severe one. The later the eruption the more severe the case.

Dr. Hein, of Palouse, said: I am not afraid of diphtheria; I am not afraid of small-pox, I am not afraid of typhoid fever, but I stand in the presence of scarlet fever with fear and trembling because there is no known remedy. As to diagnosis, I do not think it is very difficult. Given a sudden onset, high fever, vomiting and sore throat, in a child from two to ten years old, followed in a few hours by an eruption, and you are fairly sure of scarlet fever. Diagnose by exclusion. What else could it be?

Dr. Armstrong said he does not think that strawberry tongue has any special bearing on a diagnosis of scarlet fever.

Dr. White, of Colfax, said: I think the time when albuminuria appears is governed by the time of high fever.

Dr. Johnston said: The point I wish to bring out is that the strawberry tongue does not appear early, not before the fourth day. I think the diversity of opinions expressed here tonight teaches that we do not study these points as we should. I think we should keep a record of all our cases, noting in it these different questions, and in that way get at their correct answer. I believe the silver salts are of benefit in treatment of this disease, and antidiphtheretic toxin has produced good results.

Treatment of Chronic Gonorrhea.—Dr. Armstrong, of Spokane, read this paper. The doctor gave the records of nine cases, showing various results under various treatments. The best were obtained by irrigating with a mild solution of permanganate, dilating with a Kollman's dilator and injecting an oil composed of resorcin, ichthyol, balsam Peru and castor oil. Massage of seminal vesicles is absolutely necessary in those cases in which they are involved. Dr. Wilson asked if a resisting body is necessary in order to successfully "milk the vesicles." Dr. Armstrong answered no. A very slight stroke suffices, and besides, the patient could not endure the pain if a resisting body opposed the finger. Urinary antiseptics should be administered in all cases.

Dr. Johnston's resolution amending the bylaws so that Article I shall read: "The regular meetings of this society shall be held quarterly on the *third* Monday of each October, January, April and July," was passed unanimously. This change was made because of the fact that other societies meet early in the month and visiting was practically prohibited. There is now no conflict of meetings so far as this society knows.

Dr. Nelson, on behalf of the Washington Agricultural College, tendered to the society the use and benefits of the college pathologic laboratory. Receptacles containing a preservative solution will be sent to members on application. In these, specimens can be forwarded to the college, where they will be examined by the college pathologist and a report of the findings returned. The college will thus be able to secure specimens for use in teaching and the society to enjoy the advantages of a laboratory diagnosis.

On motion of Dr. James the tender was accepted and a vote of thanks given the college therefor.

WHATCOM COUNTY MEDICAL SOCIETY.

President, C. L. Holt, M. D.; Secretary, F. J. Van Kirk, M. D.

The regular monthly meeting of the Whatcom County Medical Society was held in Odd Fellow's Hall, Whatcom, on Monday, January 11, 1904, President Holt in the chair.

The minutes of the last two meetings were read and approved.

A communication from the Secretary of the State Medical Society, relating to payment of yearly dues from this society, was read and placed on file.

The Secretary presented a communication from Dr. F. H. Coe, requesting this society to name the month which they preferred for the coming meeting of the State Association. By unanimous vote, the month of July was held to be the most convenient for all.

The resignation of Dr. C. S. Teel, as member of this society was accepted.

Upon motion by Dr. W. H. Axtell, the secretary was instructed to extend to Dr. F. H. Coe our most hearty thanks and appreciation of the courtesies extended to this society at our last meeting.

The application for membership of Dr. S. H. Johnson was reported favorably from committee. By unanimous vote the doctor was duly elected a member of this society.

Dr. R. S. Markley informed the society that he has been appointed legislative member from Whatcom County for the ensuing year.

The yearly report of R. S. Markley, as treasurer, showed a balance on hand of $25.

PRESIDENT'S ADDRESS.

The Standing of the Physician in the Community.—The program of the evening consisted of an address by retiring President, Chas. L. Holt, upon this subject. The paper was extremely interesting and was discussed by every member present. Upon motion by Dr. Axtell, the society extended to Dr. Holt a hearty vote of thanks for the faithful an efficient manner in which he had conducted the affairs of his office during the past year.

The annual election of officers then took place, resulting as follows: President, Dr. D. E. Biggs; Vice-President, Dr. Frank J. Van Kirk; Secretary, Dr. Wilbur U. Hunt; Treasurer, Dr. H. Thompson. Also were elected the committees on Ethics and Admission, Programs and Arrangements. The meeting adjourned to meet the second Monday in February.

BOOK REVIEWS.

Edited by
KENELM WINSLOW, M. D.

The Practical Care of the Baby.—By Theron Wendell Kilmer, M. D., Associate Professor of Diseases of Children in the New York School of Clinical Medicine; Assistant Physician to the Out-Patient Department of the Babies' Hospital, New York; Attending Physician to the Children's Department of the West Side German Dispensary, New York. 12mo. Pages xiv-158, with 68 illustrations. Extra Cloth, $1.00, net, delivered. Philadelphia. F. A. Davis Company, 1914-16 Cherry Street, Publishers.

This book is well-named. It is essentially practical in all respects and this is secured effectively by the illustrations which picture the clothing, utensils in feeding, mode of carrying and lifting the infant, how to give enemata, etc. The directions for artificial feeding are simple and wisely given—the formulae being properly accredited to Holt—and superfluity in choice of milk-mixtures is avoided. What is still more useful than a large choice of formulae is the information as to the steps to be taken when the food disagrees in various ways. The more common infantile disorders are described and, in most cases the necessity for calling a physician is emphasized, but not in all cases, as in the section on scarlet fever the treatment is outlined, but no advice of this kind is added. Considering the prevalcnce of "Christian? Science?", and the requirements of boards of healths, and the penalties attached to medical neglect of children, it would be well in giving advice to parents concerning infantile diseases to interpolate a word as to the urgent need of securing medical aid at the first suspicion of the presence of a contagious disorder. Taken as a whole, the book is one of the most direct, satisfactory and plainest of the host of similar works which we have seen. WINSLOW.

The Medical Epitome Series.—Series edited by V. C. Pederson, A. M., M. D. Lea Bros. & Co., publishers, Philadelphia and New York.

Anatomy by Henry E. Hale, A. M., M. D. 389 pp., 71 engravings.

Organic and Physiologic Chemistry, by Alexius McGlannan, M. D., 246 pp., illustrated by nine engravings. Comprising the consideration of general principles; the constitution, decomposition and classification of organic compounds; the hydrocarbons; the alcohols; the aldehydes; the organic acids; the polybasis and hydroxy acids; the ethers, ersters; the fats and fat oils; nitrogen in organic compounds; the carbohydrates; the benzene or aromatic series; benzine derivatives containing nitrogen; the proteins; the methods for quantitive analysis; chemical changes in living organisms; chemical composition of animal organism; milk; digestion; respiration; elimination of waste; food and diet metabolism and important physical and chemical data.

Physics and Inorganic Chemistry by Alexius McGlannan, M. D. 215 pp. Illustrated by 21 engravings. Containing the consideration of general principles of physics; heat; light; electricity; magnetism the fundamental principles of chemistry; the elements and chemical compounds; chemical combination and decomposition; nomenclature; the consideration of the principal elements in detail, and important physical and chemical data.

These manuals are fine examples of multum in parvo in matter and cost. They differ from the usual quiz-compends in having the conventional questions at the end of the chapters and thus not disturbing the continuity of thought of the reader. The series is to embrace the whole realm of medicine and, if the forthcoming numbers are as satisfactory as those at hand, the set will reward both reader, writer, editor and publisher. The character of these manuals is very high, and we heartily recommend them for students or practitioners who desire to have ready remembrancers which are up-to-date, and costing but little. WINSLOW.

The Self-Cure of Consumption Without Medicine.—Showing the Twentieth Century methods of combatting this disease, with a chapter on prevention of Consumption and other diseases. By Charles H. Stanley Davis, M. D., Ph. D., member of the Connecticut State Medical Society, physician to the Curtis Home for Old Ladies and Children, author of "Training and Education of Feeble-Minded, Imbecile and Idiotic Children," etc. In cloth, 12mo, 176 pp. Postpaid, 75 cents. E. B. Treat & Co., publishers, 241-243 West 23rd St., New York.

The object of this book is to show how, from its beginnings to its latest stages, before actual decay of the lungs takes place, it can be cured in at least 95 per cent. of the cases, and this without the use of medicine. It contains the results of the most prominent sanitorium methods in this country and Europe, with many of which the author has a personal acquaintance. The book is one evidently written for popular consumption—if such a paradoxical phrase in the premises is permissible—and as a whole, is a good presentation of the subject for general instruction. Some positive affirmations we would disagree with, as "the tuberculin test should not be employed in man. There is a practical agreement that its use is unjustifiable." And we also vehemently dissent from the statement that, "the x-rays can give no material aid in the early diagnosis of incipient disease." We know, personally, of several cases in which both these methods yielded positive results when expert, physical exploration and examination for bacilli were negative, until a later period. There are several other declarations to which we would take exception, but the general object of the book is clearly and forcibly stated, and every contribution, which educates the public in this important matter, should be received with thankfulness. WINSLOW.

REPORT OF CONTAGIOUS DISEASES.

To the Washington State Board of Health for January, 1904.

Counties.	Smallpox		Scarlet Fever		Diphtheria		Typhoid Fever	
	Cases	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*
Adams	1	0	2	0	0	0	0	0
Asotin	0	0	0	0	43	2	0	0
Chehalis	0	0	0	0	0	0	1	0
Clarke	0	0	0	0	0	0	1	1
Columbia	1	0	1	1	4	1	0	0
Douglas	0	0	7	0	3	0	7	0
Garfield	0	0	2	0	0	0	3	0
Jefferson	0	0	0	0	1	1	1	1
King	10	0	22	0	0	0	5	0
Kittitas	0	0	1	0	0	0	0	0
Klickitat	11	0	0	0	0	0	1	0
Lewis	0	0	0	0	0	0	2	0
Lincoln	0	0	2	0	14	1	0	0
Okanogan	0	0	0	0	7	3	0	0
Pacific	1	0	0	0	10	2	3	0
Spokane	4	0	4	0	6	0	2	0
Thurston	0	0	6	0	0	0	7	0
Walla Walla	2	0	0	0	0	0	0	0
Whatcom	0	0	6	2	6	2	0	0
Whitman	2	0	5	0	16	2	0	0
Yakima	8	0	1	0	9	2	1	0
Seattle (city)	6	0	77	2	4	2	6	3
Spokane (city)	0	1	4	0	16	0	7	1
Tacoma (city)	0	0	3	1	2	0	39	10
Total	46	1	143	6	141	18	86	16
January, 1903	92	0	63	0	24	0	0	0

Elmer E. Heg, Secretary.

MEDICAL SOCIETIES.

Name. Meetings Held.

Washington State Medical Association..................1904—Seattle
President, F. H. Coe, M. D.; Secretary, A. H. Coe, M. D.

Chehalis County Society ....Second Tuesday—Aberdeen
President, D. A. Schumacher, M. D.; Secretary, J. W. Scamell, M. D.

King County Society ....First and Third Monday—Seattle
President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

Pacific County Society ....
.............Third Monday of Jan., April, July, Oct.—South Bend
President, G. W. Overmeyer, M. D.; Secretary, Mary W. Gunwell, M. D.

Pierce County Society...........Second and Fourth Tuesday—Tacoma
President, C. Quevli, M. D., Secretary, A. de Y. Green, M. D.

Skagit County Society ....
President, A. C. Lewis, M. D.; Secretary, R. J. Cassel, M. D.

Snohomish County Society.................First Thursday—Everett
President, W. C. Cox, M. D.; Secretary, C. B. Betts, M. D.

Spokane County Society...................First Thursday—Spokane
President, C. S. Kalb, M. D.; Secretary, Geo. A. Gray, M. D.

Walla Walla County Society.........Second Wednesday—Walla Walla
President, N. G. Blalock, M. D.; Secretary, Y. C. Blalock, M. D.

Whatcom County Society.................Second Monday—Whatcom
President, D. E. Biggs, M. D.; Secretary, W. N. Hunt, M. D.

Whitman County Socity.........Third Monday of Jan., Apr., July, Oct.
President, W. N. Divine, M. D.; Secretary, R. J. Skaife.

Yakima County Society..............First Tuesday—North Yakima
President, T. B. Gunn, M. D.; Secretary, David Rosser, M. D.

Oregon State Medical Association......................1904—Portland
President, W. T. Williamson, M. D.; Secretary, L. H. Hamilton, M. D.

City and County Medical Society of Portland...First Wed.—Portland
President, R. L. Gillespie, M. D.; Secretary, A. D. Mackenzie, M. D.

Multnomah County Medical Society..........First Tuesday—Portland
President, A. Tilzer, M. D.; Secretary, L. Victoria Hampton, M. D.

Montana State Medical Association......................1904—Butte
President, T. J. McKenzie, M. D.; Secretary, B. C. Brooke, M. D.

Silver Bow Medical Society....Second and Fourth Wednesdays—Butte
President, T. J. Sullivan, M. D.; Secretary, Grace W. Cahoon, M. D.

Idaho State Medical Association ....1904—Lewiston
President, J. L. Conant, Jr.; Secretary, E. E. Maxey, M. D.

Northern Idaho District Medical Society.............June 9—Lewiston
President, C. L. Gritman, M. D.; Secretary, C. D. Parsons, M. D.

Southern Idaho District Medical Society.................July—Hailey
President, W. E. Hargrave, M. D.; Secretary, R. E. Smith, M. D.

British Columbia Medical Association...............1904—Vancouver
President, O. M. Jones, M. D.; Secretary, W. D. Brydone-Jack, M. D.

Vancouver Medical Society ....Vancouver
President, A. P. Proctor, M. D.; Secretary, J. S. Conklin, M. D.

Corrections and additions to this list are requested from societies reached by this journal.

SEATTLE NURSES' BUREAU

If you need the services of a Graduated Nurse call on the Superintendent

MRS. A. W. HAWLEY

1115 Madison Street, or Phone John 411, and she can supply you on short notice.

Graduated Nurses' Association

NAME.	QUALIFICATION.
BEAN, MISS ALTA	Graduate Grace Hospital, Detroit.
BECHDOLT, MISS MARGARET	Graduate Seattle General Hospital.
BLASHFIELD, MISS ELLA	Graduate U. B. A., Grand Rapids, Mich.
BARR, MRS. EMMA L.	Garduate Mt. Sinai Hospital, New York.
BUTTON, MISS AGUSTA	Graduate Seattle General Hospital.
BAKENHUS, MISS MELINDA	Graduate Bethesda Hospital, Chicago.
BENDER, MISS JULIA M.	Graduate Eastern Illinois Hospital.
BRYSLAND, MRS. LILLIAN	Gradate Seattle General Hospital.
CROWL, MISS FLORENCE I.	Graduate Seattle General Hospital.
DAM, MRS. EVA L.	Graduate Seattle General Hospital.
DE VECKMON, MRS. E.	Graduate Seattle General Hospital.
FREMMING, MISS THORA H.	Graduate City and County Hospital, St. Paul.
FEEHAN, MISS ANNA	Graduate St. Joseph's Hospital, St. Paul.
MISS ROSE FINDLEY	Graduate Victoria Jubilee, Dominion General Hospital, Kingston.
GILLISPIE, MISS CORA E.	Graduate Illinois Training School for Nurses.
GREEN, MRS. ANNIE G.	Graduate Good Samaritan Hospital, Portland.
GREGG, MISS MINNIE	Graduate Women's Hospital, Syracuse, N. Y.
HUGHES, MISS M. A.	Graduate Dublin General Hospital.
HUBBS, MRS. F. H.	Graduate Philadelphia Hospital.
HERDMAN, MISS LILLIAN E.	Graduate Seattle General Hospital.
HEMPEL, MISS CLEO	Graduate Colorado Training School, Denver.
HUMPHREYS, MISS ALICE HOYD	Graduate Fabiola Hospital, Oakland, Cal.
KENNEDY, MISS	Graduate St. Luke's Hospital, Duluth; Sloan Maternity, New York.
LACKORE, MISS LILLIAN	Graduate Wesley Hospital, Chicago.
LAEMMERICH, MISS LOUISA	Graduate Winona General Hospital.
LIVERMORE, MRS. AGNES B.	Graduate Minnesota Training School.
McGREGOR, MISS HATTIE	Graduate Seattle General Hospital.
NEWTON, MISS G. W.	Graduate Royal Jubilee Hospital, Victoria.
RAY, MISS JENNIE	Graduate Seattle General Hospital.
SHROEDER, MISS H. L.	Graduate Seattle General Hospital.
SLATER, MISS GRACE	Graduate Eastern Illinois Hospital.
SLATER, MISS MAME	Graduate Eastern Illinois Hospital.
SHIACH, MISS MARY	Graduate Seattle General Hospital.
STRAHL, MISS INEZ	Graduate Asbury Hospital, Minneapolis.
STRONACH, MISS MINNIE	Graduate Brompton Hospital, London.
MISS MARGARET UNDERWOOD	Graduate Buffalo General Hospital.
WAGNER, MISS IDA	Graduate Riverside Hospital, Milwaukee.
WANAMAKER, MISS NIDA	Graduate Seattle General Hospital.

NORTHWEST MEDICINE

March, 1904.

ORIGINAL CONTRIBUTIONS.

LEPROSY IN THE SULU ARCHIPELAGO.*

By J. W. Amesse, M. D.

Assistant Surgeon, P. H. & M. H. S.

JOLO, PHILIPPINE ISLANDS.

So many pages of Moro history have been written with the point of the sword, that a digression in more peaceful vein may not be out of place at this time, when the nucleus of Civil Government is forming, and the advent of so many people wholly unfamiliar with the country is expected.

I have chosen for this paper the subject of leprosy, because it is an indigenous disease, and no insignificant member of that endemic plague trinity, of which dysentery and malaria have furnished such world-wide study. The notes have been obtained from careful observation extending over a period of five months, during which time a number of the larger islands were visited, and from personal interviews with many representative Moros from various parts of the Archipelago. Unfortunately, political differences between our Government and the natives, increasing as it did their inherent distrust of the white man and his inevitable note book, prevented, in some instances, that freedom of communication so essential in investigations of this kind, but it is believed that sufficient reliable data were obtained to be of use when the ultimate question of segregation presents itself.

It would be strange if even so difficultly communicable a disease as leprosy did not flourish in these islands, once a focus has been established. Meteorological conditions, the squalor and general wretchedness of the natives, crowded together in vile single-roomed huts, their half-clad bodies disclosing a protean array of dermatoses,—all contribute to the growth of the specific organism, and the transmission of the disease.

Leprosy has existed in the Sulu group since early in the 18th century, and before the arrival of the Chinese, though these "Pig-tailed Argonauts" have doubtless been an important factor in its dissemination since their trading centers were established in 1755. It is easy to believe the first cases were carried here by Moro pirates, who ravaged the entire Philippine coast for centuries, and frequently returned to rendezvous in these waters. Even at Manila, Foreman tells us, Musselman corsairs were feared as late as the year 1800, and at this time Luzon had been a center of infection for more than one hundred and fifty years. It is also probable that Javanese lepers, escaping from their own country, where lazerettos were in vogue as early as 1657, established themselves in neighboring islands and contributed to the infection of Sulu. Later on, when the Spanish Government founded penal colonies in the neighboring island of Mindanao, and garrisoned its outposts with Tagalog and Visayan soldiers, recruited from provinces where leprosy was common, numerous cases appeared among the Filipinos, but at no time was segregation of these unfortunates attempted.

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*Read before the King County Medical Society, Seattle, Wash., Feb. 1, 1904.

The subjoined history of one of these cases well illustrates the indifference manifested by these exiles toward all sanitary matters; an apathy now bearing rich fruitage in the enormous mortality from tuberculosis, syphilis and enteric disease. From all the sources of information accessible at this time, it is believed there are three hundred and fifty lepers in the Sulu group, which, allowing these islands a population of 85,000, implies a ratio of 4 to 1,000. This proportion is lower than that found in the Hawaiian Islands, New Caledonia, British North Borneo, or Java, but is much greater than the percentage in India, where leprotics are segregated in suitable asylums.

Both forms of the disease are recognized by the Moros under the general name "Epul," the anesthetic type being considered non-contagious and its victims allowed to live out their lives with the family, while the exudative or tuberculous form is looked upon as the most baneful disease that afflicts the race. Their views on its etiology are at once interesting and puerile, colored as they are with the vein of superstition that pervades their entire folk-lore and daily life. They believe, (1) That leprosy can originate, de novo, through sorcery or the enchantment of some enemy; (2) That it may follow continued and intimate association with one already stricken with the tuberculous form; (3) From a fish diet, especially when restricted to one species known among the Moros as the "Ty Yook."

The theory advanced by the distinguished leprologist, Jonathan

Hutchinson, whose convictions concerning this factor in the etiology of the disease have recently been strengthened by further research in India, would find many earnest advocates among these primitive people. In the island of Panducan, twenty-five miles northwest of Jolo, there are fifteen lepers in a population of about four hundred; these people subsisting almost exclusively upon sea food, preferring, always, to eat it dried and uncooked. While it is recognized that, until the chain of evidence is complete and the bacillus of Hansen demonstrated in the food itself, such observations as these can be of but subsidiary value to medical science, the fact is strongly borne in on one that here we may find the solution of the question.

Another reason (4), assigned for the presence of sporadic cases, is the visitation of Divine wrath, following certain personal pollutions forbidden by the Koran with even greater emphasis than are similar transgressions in the Bible of the Christians.

Treatment. As witchcraft is in many instances held responsible for the appearance of leprosy in a community, so do charms and amulets prevail in its prophylaxis and treatment. Perhaps the most gruesome of these ceremonies is that practiced in the islands of Tawi Tawi and South Ubian, where the natives have made little or no progress in civilization. The patient is taken to some unfrequented spot in the woods or mountains, where a bullock is slaughtered and dressed to the point of splitting the spine. The leper, perfectly naked, is then placed in the body cavity and remains there for twenty-four hours, during which time the vigorous "tom-tom" of his friends and the incantations of the medicine-man are supposed to transfer to the carcass all the impurities of the individual, who is expected to emerge from his extraordinary entombment sound and whole. In other parts of the Archipelago, tuberculous lepers are driven from their homes and usually find refuge in one of the numerous uninhabited islands near at hand. The following cases are presented to illustrate the types encountered in Sulu:

Case 1. Filipino laborer, age 37; native of Pampanga Province, Luzon, exhibiting characteristic lesions of the combined anesthetic and tuberculous form. So far as leprosy is concerned, his family history is clean, though the man has seen enough of the disease in his native village to recognize it when it appeared in his own person. In 1893, he enlisted in the Spanish Army, and was sent to garrison at Jolo, where he served until the evacuation in 1899. He then obtained employment from the American Provost Marshal and worked steadily as a scavenger up to May, 1903, when my attention was called to him rather forcibly, by encountering the leper in my own bathroom. He was immediately isolated, together with his wife (who had for several years borne her share of the family expenses by doing laundry work for the troops), in a nipa shack beyond the main gate of Jolo, while the house they had occupied was repeatedly disinfected, and allowed to remain vacant. The patient's attention was first attracted to the disease three years ago, by perceptible weakness of the muscles in his right hand, and diminished sensation along the ulnar side of the arm.

Soon after a macular eruption appeared on the face, chest and hips; the eye-brows were lost; the ear lobes enlarged and nasal catarrh developed. At the time of examination, the man presented a typical picture of leprosy in an advanced stage. The nerve involvement had gone on to complete anesthesia; the nasal bones were absorbed; there was alopecia of the ciliary region, cloudiness of the cornea, and masses of lepromata studded the face, giving the characteristic expression. The man's wife shows at present no evidence of the disease but, as is so frequently observed in these cases, the marriage has been a sterile one.

Case 2. Moro fisherman, age 40, native of Panducan Island: a leper for ten years. Family history not obtainable. Through an interpreter, the patient expressed the belief that he was infected by an "Evil Spirit" from a turtle he captured one day while out fishing. The following day violent pains in both arms were noted, succeeded later by a numbness which has remained. I assured him this was the shortest incubation period on record, but the Moro appeared to derive small comfort from this somewhat questionable distinction. Examination shows an almost classical case of nerve leprosy, with complete anesthesia below the elbows and along the dorsum of the right foot. The primary contractures have been followed by mutilations, resulting in the loss of three fingers and two toes, with stumps still showing extensive ulceration. There are no facial changes, no eruptions of any kind, and the man's general health is excellent. He is the father of seven children, all born since the onset of the disease, but neither they nor his wife are lepers.

ACNE AND LEPROSY; CONTAGIOUSNESS OF LEPROSY.*

(Abstracts from Greek Journals.)

By G. N. Macridakes, M. D.,

SEATTLE, WASH.

Dr. G. Philaretopoulos, Professor of Dermatology in the University of Athens, gives in a late number of *Iatrikos Manytor*, published at Athens, an interesting account of lepra leontina and the arrangement of the hypertrophic lesions which give rise to the *facies leontina*.

Tubercular growths are found over the eyes and along the sides of the nose, giving rise to deep furrows or wrinkles between them. A picture of a woman who has a typical leontine face is reproduced; the lesion here is acne hypertrophica. Another face is presented in which the true lesion is that of leprosy, though the disease has assumed the form of an acne. In spite of the similarity in appearance, he states that the diagnosis is comparatively easy.

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*Read before the King County Medical Society, Seattle, Wash., Feb. 1, 1904.

The hypertrophic areas in leprosy are anesthetic and in addition there is wasting of the tips of the fingers. Acne is free from areas of anesthesia and there is no accompanying atrophy. The course of acne is at times much more rapid than is that of leprosy. The whole face is occasionally involved in a few days.

Acne and leprosy may occur simultaneously, in the same individual. The presence of hair in the eyebrows is considered to be against leprous infection. Dr. Philaretapoulos has, however, seen many lepers in Creta in whom the hair of the eyebrows was present. As the roots of the hair are in time destroyed by the lepra bacillus, absence of the hair is additional evidence in favor of leprosy.

Dr. M. Hadjimichales, of the Athens faculty, writing in *La Grece Medicale,* on Leprosy, calls attention to the contagiousness of the disease. Heredity is believed to be a small factor in its spread.

The incubation period is sometimes as long as thirty years. The surest sign of the disease is the presence of the bacillus of Hansen in the cutaneous lesion or in the discharges from the nose. The finding of this organism he considers the crucial point in distinguishing leprosy from Scleroderma and Morvan's disease.

Syringo-myelia is often an accompaniment of leprosy. It is caused by the invasion of the spinal canal by the lepra bacillus. Not all cases of syringo-myelia are of leprous origin, though the tactile phenomena present in leprosy may simulate this disease, when the lesions are purely peripheral and not in the cord.

At the Pan-Hellenic congress, held in Athens in 1901, it was brought to notice that there are about 200 lepers in Greece. There may be more, as some secrete themselves from the public view. One observer did not think that the bacillus of Hansen was the sole cause of the disease, but simply occurred in the lesions.

The Government has been memorialized to establish isolation colonies for the unfortunates.

No new form of treatment was discussed, though it was generally agreed that the baths of Hypate, near Sparta, were of value in mitigating the cutaneous lesions of the disease.

ABDOMINAL CONTUSIONS.*

By A. E. Bolton, M. D.

VICTORIA, B. C.

By this term I mean injuries to the abdominal wall and contents by some force applied to the surface of the body, without resulting in a penetrating wound of the abdomen. These injuries are not infrequent in industrial centers. A couple of decades ago the more severe of such cases were diagnosed as grave internal injuries and left to nature, with a large percentage of deaths. At the present stage of surgical science, while we cannot always accurately diagnose the exact lesion, we should be able to recognize symptoms that indicate intra-abdominal exploration, and it is important that this should be done as early as possible in the history of each case.

My object in bringing up this subject for discussion is that we, as general practitioners, may have our memories refreshed upon general points of diagnosis and perhaps learn new lessons from each other's experience. I will first draw your attention to some general considerations stated by recent authorities and then rehearse brief notes of some cases occurring under my own observation, and that of fellow practitioners, in this city during the past year.

Mechanical Considerations. An expected blow upon the abdomen will be received upon rigidly contracted muscles, and the viscera protected, while one unexpected will find the muscles relaxed, and the force will be expended upon the internal organs. The stomach or bowels will be more readily ruptured if distended with food or gases.

Symptoms. 1. External ecchymosis. The amount of visible bruise of the skin does not necessarily bear any relation to the severity of the internal lesion. This will be demonstrated in some of the cases to be described, where little or no external signs accompanied the most severe internal injuries.

2. Shock. Older writers give this as the chief symptom of injuries to the abdominal viscera. The literature and personal experience from which the material for this paper is drawn show that shock is the most unreliable of symptoms, as some of the most serious injuries are followed by no appreciable shock.

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*Read before the British Columbia Medical Association, Victoria, B. C., October 30 and 31, 1903.

3. Temperature tells us very little, especially in the early hours when diagnosis is most difficult and yet most important. There is a fall of temperature corresponding to the amount of duration of shock, and a rise with reaction. A secondary fall below normal indicates serious trouble.

4. Pulse may not be altered in rate or force when shock is absent, although the injury may be severe. Acceleration after reaction is a bad indication.

5. Respiration is quiet and shallow in presence of shock. Rapid thoracic breathing is an important early sign of abdominal injury.

6. Vomiting immediately after accident is unimportant, later it has graver significance.

7. Thirst in reaction indicates internal hemorrhage.

8. Dullness in the lateral regions indicates hemorrhage or rupture of the bowel or pre-existent cyst.

9. Hematuria indicates general injury to the kidneys. Catherization should not be omitted, and the failure to find urine in the bladder indicates rupture of that viscus.

10. Tympany progressive and continuing a day or more after injury is a symptom of increasing gravity.

11. Pain without rigidity may be from contusion of skin and muscle, but when associated with rigidity, and especially when deep and radiating, indicates serious trouble.

12. Tenderness with pain is important and may assist in localizing the injury.

13. Rigidity is the most constant and most reliable of the early symptoms. There is an increasing boardlike rigidity that is characteristic of severe intra-abdominal injury.

14. Abdominal facies once seen can be better recognized by recollection than by description. It may be absent in severe injury but when present is pathognomonic of severe lesion.

Case 1. Mill hand, age 40, struck by a piece of timber flung from a circular saw. The only external sign of injury was a small bruise, a little below and to the left of the navel. Abdominal muscles were rigid, pulse full and strong and rate 80; was given a stimulant and was asked to report in three hours. Next seen twelve hours later, temperature 100°, pulse 72, pain and rigidity increasing. Had him removed at once to Jubilee Hospital. Three hours later temperature 99.2°, pulse 68. Consultation with three confreres with as many different opinions at last resulted in decision of immediate operation. Conditions found were blood and intestinal contents free within the abdomen. The ileum was completely severed in two places, within six inches of each other directly over the promontory of the sacrum. The adjacent colon was not ruptured.

Case 2. Miss B., age 45, native of Iceland. Injured by falling over a loose plank in the sidewalk. Early symptoms were pain but no shock; she walked two blocks to her home. Seen by my colleague, Dr. Ernest Hall, eighteen hours later, who sent her at once to the hospital. Symptoms were pulse 110, temperature 101.5°, moderate pain and tenderness over all parts of the abdomen with fluctuation. Immediate operation revealed the abdomen filled with the contents of a ruptured hydatid cyst, which occupied the left lobe of the liver.

Case 3. Male, age 20, seen with Dr. Duncan. Injured by several sacks of flour falling upon him, throwing his abdomen against a barrel. The only external injury was a slight ecchymosis at the navel. Very little shock and very little pain at first. When I saw him, four hours after the injury, there was marked rigidity and pain and tenderness to the right of the umbilicus, intense thirst but no vomiting; breathing was shallow and rapid, thoracic in type; complained of intense pain in the supra-scapular region, caused, in my opinion, by the extreme effort of the accessory muscles of respiration, in that region. Operation by Dr. Davie, at St. Joseph's Hospital, a few hours later showed the abdomen filled with blood from a tear in the mesentery of the ileum. The omentum was also torn from the transverse colon, with other minor injuries.

Cases 4 and 5, occurring in the practice of Dr. Frank Hall, were both young girls. One was injured by the kick of a horse and the other in a bicycle accident. One proved to be a case of rupture of the liver and also of the stomach, the other of the liver alone, the former presenting very little shock, while the latter was in profound shock when first seen.

Case 6 (reported by Dr. F. W. Hall). Laborer, aged 52; at work excavating one hour after eating a hearty breakfast, tunneling under a bank some fourteen feet high. A large block of clay, weighing between 1,500 and 2,000 pounds, loosened and struck him, throwing him on his right side, which position he was found in, being partially covered with the clay. He suffered severely from the shock. Radial pulse not perceptible; conscious; no vomiting. He was at once removed to the hospital and placed on the table, being immediately transfused. Examination disclosed a double fracture of the pelvis. Upon passing a catheter, no urine was found, but a little blood adhered to the end of the instrument upon withdrawal. Upon opening the abdomen, I found a rupture, about three quarters of an inch in length, in the posterior part of the bladder, and the ileum completely severed in two places within a length of three inches, the rent passing a short distance into the mesentery; the rectum was also torn.

In conclusion allow me to suggest that in every case of injury of the abdomen the practitioner should remember that the gravest results often follow apparently the most trivial causes, and that all abdominal injuries be considered serious until subsequent results show that the apprehension is without warrant.

SWEDENBORG'S VORTEX-RINGS AND SOME OF THEIR APPLICATIONS IN THE REALM OF NATURAL SCIENCE, WITH ESPECIAL REFERENCE TO THE SUBJECT OF THOUGHT.*

By E. R. Edson, M. D.,

SEATTLE, WASH.

Before taking up the proper subject-matter of this essay I wish to state that I owe the basis of this entire line of thought to Emanuel Swedenborg, for the principle which I wish to illustrate, as observed in various degrees or classes of natural phenomena, came to my mind as a result of reading, primarily, a description of Swedenborg's Series of Forms given in Emerson's article on "Swedenborg the Mystic" in his work "Representative Men." I cannot pay too high a tribute to the genius of Swedenborg, whose intellect was so vast that he lived far in advance of the thought of his own time (that of the eighteenth century). As a practical workman in the realm of natural science he stood, I believe, without a peer.

(1) Consideration of Elementary Natural Phenomena.

As we are entering upon a discussion of elementary natural phenomena, it is necessary, at the very outset, to consider the primary conceptions of the human mind. I believe that the most elementary conception of the human mind is that of the existence of one's own self. Secondarily, we think of that which affects our existence, and, if we think deeply enough, make note of two primary classes of ideas—those relating to Space on the one hand, and those relating to Time on the other. If we imagine that we travel to the limits of this visible Universe, we still must conceive of a space stretching beyond, a space without limit, extending in every direction to Infinity itself. And similarly, if we think backwards or forwards we conceive of Eternity in each direction. It is evident that we have these two elementary conceptions, the extent of which the mind cannot grasp, and which remain to us incomprehensible because they are infinite ideas and we are possessed of but finite minds.

Having conceived then of Space and Time as elementary ideas we think next of Matter as that which occupies Space and of Motion as that which occupies Time. Our conceptions of space are measured by the material objects which we observe, and similarly our conceptions of time are measured by the motions of these material objects, just as the rotations of our Earth upon its axis give us our days and its revolutions about the Sun give us our years. We have then Space and Matter on the one hand, and Time and Motion on the other. If now we think but one degree further, we conceive of Form, and we find that this conception follows immediately after both conceptions of Matter and conceptions of Motion. This is most clearly seen in the form of a table, thus:

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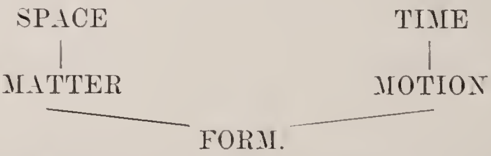
*Read before the King County Medical Society, Seattle, Wash., November 16, 1903.



We observe that the two chains of thought meet upon one common basis, that of Form, and this is the first concept, of those with which we have been dealing, which is sufficiently concrete to permit of definite illustration. We were dealing with Space in the abstract, Matter in the abstract, Time in the abstract, and Motion in the abstract, but now we come to the most elementary concrete idea, that of Form, and if we wish to represent the varying degrees of the motions of matter in its varying states of aggregation, it is evident that we must construct a series of the Forms of Motion of Matter.

This was Swedenborg's idea and consequently he thought out such a series of forms to serve as a foundation for his conceptions in regard to the phenomena of Natural Science—a scale according to which all motions could be classified as belonging to a certain type or degree. In other words he demonstrated a type of growth, of evolution, a principle in form, which can be applied, correspondingly, to the developmentary stages of matter, inorganic and organic, throughout the entire Universe. In this way have the greatest minds in all history progressed: for instance, Darwin traced the descent of man from an anatomic standpoint and demonstrated a theory which appeals to the great majority of scientific minds as being reasonable and true, and, consequently, is accepted today in the biologic world; still, his work was not as broad as was that of his predecessor, who was likewise a student of anatomy and who revealed a type of evolution, a general principle applicable to all growth.

Swedenborg began his series of forms with the Straight Line, but should have commenced earlier with the Dot, a mere speck, a Microsphere, representing the unit of growth in any kind of matter. To properly grasp this idea we must conceive of these units or microspheres as representing the result of growth in the evolutionary degree of matter next inferior, or, in other words, that matter and motion, just like space and time, recede on the one hand and proceed on the other hand to Infinity. Such a theory recognizes molecules only as the result of growth of a more elementary unit, and further, recognizes these elementary units, which may, by their multiplication, produce molecules, to be nothing else than smaller molecules, or micromolecules, which again are resolvable into their chains of component units. I mean, simply that we are confronted by Infinity on either hand, an Infinity of space, of time, of matter and of motion, and we necessarily see no end either of division or of multiplication of this matter and its motion.

I will now proceed to a description of this Series of Forms. We begin with a unit and allow this unit to reproduce, and as we ascend higher in the scale we see that each higher or superior form possesses all the characteristics of its inferiors and somewhat also is added. We should also conceive that we pass from matter of greater density to matter of lesser density, and that as we so proceed we find this matter more fluid, more motile, and more capable of evincing motion which is more harmonious. (It will be well for me to state here that by the term Harmony I mean "An agreement in relation."[1])

First Form: the Dot or Microsphere. For purposes of illustration, I will let this microsphere be considered an ethereal vortex-ring whose component parts are moving in the form of a perpetual whirlpool, following that type of vortical motion enunciated by Swedenborg, and which will be more fully illustrated later on.

Second Form: the Straight Line. Conceive that this microsphere reproduces, or multiplies, in the simplest manner and we have no longer a microsphere but a straight line.

Third Form: the Angle. If reproduction of one of these two spheres occurs again, the next simplest form may result, the angle.

Fourth Form: the Circle. By infinite reproduction of angles we obtain a circle.

Fifth Form: the Spiral. Now we may keep this circle as a base and produce upward growth of this circle, or of circular motion, by conceiving that reproduction begins in a spiral form at some point on this circle, i. e., circular motion continues, but grows upwards as well. Consequently we obtain spiral motion.

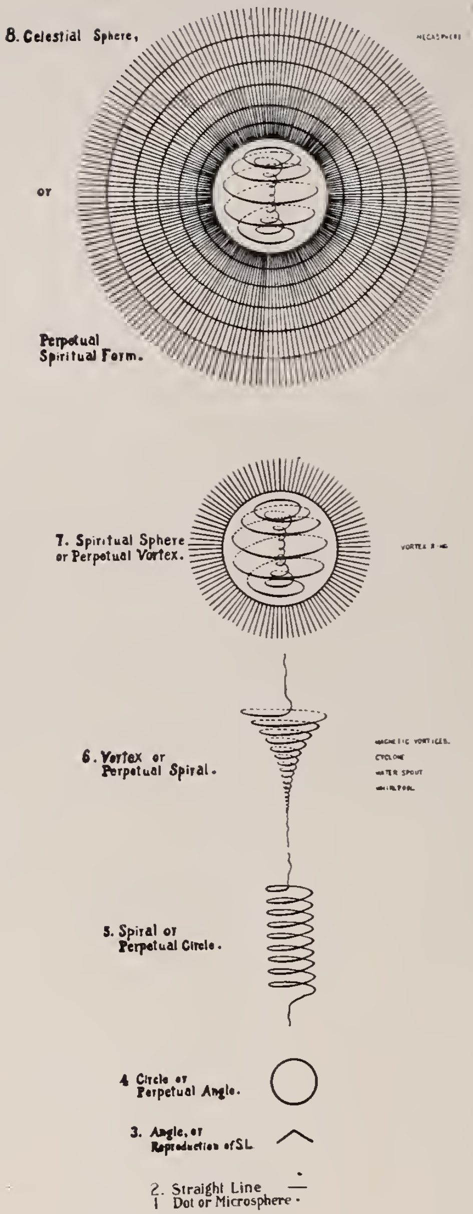

8. Celestial Sphere,
or
Perpetual Spiritual Form.
MEGASPHERE
7. Spiritual Sphere or Perpetual Vortex.
VORTEX RING
6. Vortex or Perpetual Spiral.
MAGNETIC VORTICES.
CYCLONE
WATER SPOUT
WHIRLPOOL
5. Spiral or Perpetual Circle.
4 Circle or Perpetual Angle.
3. Angle, or Reproduction of S.L.
2. Straight Line
1 Dot or Microsphere

Fig. 1. Swedenborg's Series of Forms.

Sixth Form: the Vortex. In a similar manner, if this spiral motion grows laterally, a vortex is produced. We have now arrived at a form of powerful harmonic movement, for forces acting in all three dimensions of space must of necessity, if they combine harmoniously, act together in the form of a vortex, the common property of all the forces being that they all bear a relation to the common central axis of the vortex. Consequently we see that the dreaded natural currents are of this type—the whirlpool, the water-spout, tornado, cyclone, and also ethereal vortices. It is best, when one reaches the vortex or whirlpool stage, to imagine the whirlpool in active motion, in one's imagination, to actually see it whirling, for by so doing it is must easier to see the two higher degrees of movement.

Seventh Form: the Vortex-Ring, or (Swedenborg) Perpetual Vortex. Whirlpools may be of almost infinite variety. Some whirlpools, however, become closed vortices, following a spiral course from the summit, flowing down around the outer surface of an imaginary sphere and joining the original current below, as seen in the above figure. A particle may be imagined to start from below, rise in the gradually narrowing inner whirlpool, then to rise in the upper expanding inner whirlpool, then to leave the apple-core, as it were, and sweep spirally down around the outside of the apple; then to go up through the core again. Such a form of motion is truly perpetual, in that there is no beginning or end. This form of current can be produced artificially in water, occurs in cyclonic storms of the earth's atmosphere, and is also, I believe, the type of current motion displayed by the ether.

Eighth Form: the Celestial Sphere, Megasphere, or (Swedenborg) Perpetual Spiritual Form. The Perpetual Vortex, just described, represents almost the perfection of harmonic motion. There is yet one more degree, in principle, of ascent, and that is the principle of harmonious growth from the centre, just like the growth of an apple. The concentric lines represent varying degrees of growth of the inner vortex-ring. The radiating lines are intended to convey the idea that this form of ethereal motion is luminous in some instances.

(*To be Continued.*)

THE TENT TREATMENT OF CONSUMPTION AT THE KING COUNTY HOSPITAL.*

By W. P. O'Rourke, M. D.,
Resident Physician King County Hospital.

SEATTLE, WASH.

In a consideration of the subject of pulmonary tuberculosis at the present day three facts are pretty generally accepted: First, that it is a curable disease; secondly, that the most important factor productive of such result is a nutritive one; and thirdly, that the most important extraneous agent is live, perhaps ozonized, air.

In support of the first contention, that tuberculosis is a curable disease, we have no less an authority than William Osler, who says that the post-mortem room frequently shows lungs, if not other tissues, bearing scars of evident tubercular processes, where a limiting inflammatory condition had shut off the tubercular nodule from the general system and subsequent ulceration had relieved the system of the infected spot and a perfectly healed scar was the result. In such cases the strength of the individual, so far as his life processes were concerned, was greater than that of the parasitic guest, and the unconscious host might not even have suspected that he had been entertaining the dread tubercular germ in his own system or had been suffering from anything more dangerous than, as he described it, "a lingering cold."

In another case the vitality of the host is not sufficient to win out in the struggle except under the most advantageous circumstances, and the second proposition—that the most important factor in such a contest is a nutritive one—is based upon the well-known relationship of soil and environment to seed, and that all growing things are provided by their Creator with certain protective agencies to ensure their continuance; which becomes thus an exposition of what, in the language of science, is known as the survival of the fittest.

In the normal human being the unbroken skin, by preventing access of the bacterial seed to the softer and more nutrient tissues of the inner body, acts as a fairly constant protective, but not always, and then reliance must be placed upon the leucocyte and the oxygen-bearing blood corpuscle to repel the invaders; the former to act as scavenger and the latter, probably, to strengthen the tissues and place them in a condition unfit for the growth of an anaerobic parasite.

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*Read before the King County Medical Society, Seattle, Wash., Nov. 2, 1903.

The third proposition, of course, goes hand in hand with a liberal and careful dietary, but that its importance is primary is readily seen by the results which are constantly being attained in the various sanitaria devoted to such purposes. Just what constitutes ozonized oxygen remains to be demonstrated, but that it is characteristic and has effects of its own upon living tissues is undisputable—even as fuming nitric acid possesses chemical affinities not accorded the plain acid, though both are of the same composition—and experience has shown that direct sunlight is, too, a most important factor in this arrangement of the oxygen molecules. Therefore the nearer we can get the patient to air, fresh from nature—to be permitted such an expression—and sunshine, the better our chances of success in this work.

In accordance with this view we have initiated two tent wards at the County Hospital for this class of patients, the dimensions of the larger one being as follows: Inside floor space, 16x24 feet, with an elevation of 12 feet 6 inches in the peak and 5 feet at the walls. The cover rests upon a platform, 24x32 feet, well cleared from the ground, and is supported by a frame which rests securely upon the platform, and is stayed to a rail surrounding the latter. At either end is a frame and door for exit and entrance, a ventilating window in each peak, and at the rear, jutting out over the river, a toilet. Over all is a large fly, covering also the gangway around the tent, and in the rear a canvas-enclosing screen, so arranged that the patients are protected in their journeys to and from the toilet, and a small room in which has been placed a sink connected with hot and cold water from the boiler, so that dishes, etc., used in this connection, can be segregated, washed and boiled independently of the general hospital kitchen. In the center of the tent a coal stove furnishes an ample amount of heat, and upon this rests a tea-kettle containing water, with a mixture of pine tar and Comp. Tr. Benzoin. Both sides of the tent roll up on poles from the bottom to the junction of wall and roof. At this point other poles, attached full length of the roof, roll up each side to the peak. The fly is also similarly arranged; and all these parts can be operated independently. It will thus be seen that the arrangement is practically two tents, one within the other, and the interior can be exposed completely or in sections to the direct sunlight or for more perfect ventilation.

Apropos of the utility of tent life for the treatment of consumption under such conditions as a Puget Sound climate may offer in winter, we can only say that it is purely experimental, but no one who has had experience with tubercular subjects in hospital life can doubt its efficacy in summer and autumn, as an adjuvant in any place where limited space is at command. Ventilation is always a most troublesome problem and our experience so far here has been that the patients elect most emphatically to stay in the tent when suggestion is made to moving any of them into the ward of the main building when inclement weather threatens. From a current medical journal I see, too, a New York hospital has instituted a sort of canvas roof garden for a similar class of patients to use this winter.

And now comes the question of what to do with such of these unfortunates as may be numbered among the ranks of the indigent. If they are to be kept as charges of the commonwealth, from an economic point of view it becomes simply a question of how long they are going to live and the per capita cost of conducting the institution in which they are to be maintained. Clearly, with such a lingering disease, if possible to effect a cure and return the dependent to the ranks of self-support, such would be the most reasonable method of their disposal. In many cases this end can be and certainly has been effected by transportation to a warmer and drier climate, as an adjuvant to proper medicinal treatment, the patient having the necessary inherent vitality to make a successful struggle for life if all accessory factors are favorable; but that "if" must be satisfied to balance the equation. That this is true is frequently proven by results reported from patients shipped by King County to Southern California, Arizona, and such other localities, where a better climate obtains. But the getting to such a section is to these unfortunates but half the battle. It is very difficult to obtain work in such localities and access is not to be had, usually, to the almshouse until a resident for some months in that county. The cause for such a rule is obvious, but that makes the question of what to do after he gets there one no more easy of solution or less vital to those interested.

Last Spring, while the writer was in Los Angeles, he met a former patient of the King County Hospital who had been assisted by the county some months previous in securing transportation to Lower California, and who gave him quite an insight into the manner in which things along that line are conducted in that "one lung" town. The former Seattle resident had been unable to gain admission to the almshouse, because of short time of residence, but was living in a semi-private charity called Bethlehem—a sort of mission—and trying to gain admission as a county charge.

Just the prospect of such a struggle for existence after getting to the promised land deters many sufferers from making such a move. They thus slowly wear out their lives, unless of extraordinary vitality and able to make the fight under most adverse conditions, a continual burden to the State and with no prospect of relief except through death. What shall we do?

The Federal Government is establishing sanitaria for the government employes in the high table land of the Pecos Valley, New Mexico. Why should not the various States maintain similar institutions under such conditions, also, if there is any virtue in the factors to which I have called attention, and why should not the various Medical Societies and Boards of Health make it their business to put the movement on foot? We all know how valuable could be scientific results from such systematic work, if there were no other consideration, and scarcely a Legislature meets to represent the State of Washington which does not number among its members from one to five representatives of our honorable profession. Is it worth their while?

CLINICAL REPORTS.

A CASE OF PERSISTENT HICCOUGH.

By Clarence A. Smith, M. D.
SEATTLE, WASH.

Mr. McL., age 40 years, plasterer. He worked at his trade, in usual health till March 31, 1903. That night, about 2 A. M., he was wakened by hiccough, no cause being apparent. Next day he went to work but was obliged to cease on account of gastric pain from the hiccough. He treated himself in his room until April 2, when I was called.

He said he had had gastric pain and had vomited several times. He was chronically constipated, for which he took Garfield tea each night. No abdominal pain could be discovered. Temperature normal, pulse 35 to 40, full, irregular; tongue coated. The hiccough continued regularly. Ordered cathartic, strychnin gr. 1-30 every 4 hours; morphin gr. ¼ every 4 hours for 4 doses.

April 3. Patient feels well but annoyed by hiccough, which persists. Ordered Bromid Potass. and Sod. aa 30 gr. every hour during day.

April 4. Slept some last night, but hiccough did not cease. Gave morphin gr. 1-3 hypodermically and continued bromides.

April 5. Some sleep last night. Hiccough continued. This A. M. gave chloroform, dram 1, by mouth and repeated in half hour. No effect. Used two cell Faradic battery, full strength, one pole over stomach and the other over diaphragm posteriorly. No result. Ordered hypodermic of morphin gr. 1-3 and hyoscin gr. 1-50 at 7 and 10 P. M.

April 6. Slept about three hours last night without hiccough. It began again this morning. Ordered Hoffman's anodyne, dram 1, every half-hour for six doses. By mistake it was continued all day and part of night. At night gave hypodermic of morphin, gr. 1-2, and atropine, gr. 1-60, to be repeated in four hours.

April 7. Slept six hours last night without hiccough. Began again this A. M., but not so severe. Ordered bromidia and neurosine, of each dram 1, every hour for six doses. No effect. Then gave chloroform, dram 1, every half-hour for four doses, with no result. Bowels move freely; takes nourishment well; pulse 60. Morphin, gr. 1-2, and atropin, gr. 1-60, at 7 and 9 P. M.

April 8. Slept six hours last night without hiccough, but began again this A. M. Says he feels first rate. Gave ammoniated tr. Valerian, dram 1-2, every hour for six doses. Hiccough less severe during day and, at times, stopped for a half hour. Morphin and atropin, two doses as usual at night.

April 9. Hiccough ceased at midnight. None all day. Patient out of bed in P. M. Tongue coated, but appetite good. Pulse 50. All medicine stopped.

April 10. No more hiccough. Patient discharged from hospital. I saw the man at intervals during the following six months and learned that he had no recurrence. I was unable to discover the cause of this attack. Out of all this mass of medication, most of which did no good, I believe the morphin and atropin was the effectual agent in checking the spasmodic contractions. If the patient had been kept in a partially narcotized state for some time he might have recovered sooner.

NORTHWEST MEDICINE

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SLIGHT AILMENTS.

If we stop to reflect and consider the total number of people that call upon us for aid when they are not "feeling well," as the expression is, and separate out those that have some real organic disease to be diagnosed and treated and those that have simply some derangement of one part or another, probably only functional, we will find that the latter, properly called slight ailments, make up a very considerable portion of the cases.

Under this broad classification many things can appropriately be placed, but we must be careful not to be too broad and liberal with this, our convenience, and class "symptoms" of some great organic disease with slight ailments. How common it is for us to say to a patient, you have biliousness, or rather, you are bilious, you have dyspepsia, indigestion, intestinal flatus, neuralgia, neurasthenia, muscular rheumatism, malaria, constipation, nervous headache, etc., etc., all of which things may be and must at times be true, but the symptoms leading us to specify such conditions may be only those of some organic disease. Many instances of such errors come to us to our sorrow.

That we should treat these conditions when they are presented is as essential as the treatment of all forms of organic diseases, and this treatment will result more happily in many cases of the former, since many of the latter are actually incurable. Again, it is the prime object of our profession to relieve suffering of all kinds, and those who come to us complaining of these things,—slight in our eyes—have as much reason to expect us to take an interest in their cases and endeavor to alleviate them, if possible, as if they had typhoid fever, pneumonia, or such ailments.

Should we peruse some of the writings of our forefathers we would see that more attention was paid by them to the actual treatment of patients proportionately to their knowledge of conditions than is done by ourselves, and perhaps more attention given to their comfort than at present. Yet our knowledge of such matters is different. We do not mean to belittle those to whom the greatest admiration and respect is due as the pioneers of our present honorable state. They had not the pathologic and bacteriologic researches on which to found a basis of opinion or diagnosis and likewise a basis of treatment. We believe that, with our increasing knowledge, individual slight ailments are being eliminated so that the group of such diseases is growing smaller each year.

Dr. Lionel Beale has given us the only book we know of upon this subject, and in it many of us can find food for reflection and additions to our knowledge of disease, as well as many suggestions for the betterment of our patients' physical and mental state. Physicians who have come from a college course or a hospital service have not by any means the same advantage as one who has had the same course and, in addition, some practical experience under the guidance of an older, general practitioner, to whom the study and relief of the ailments of mankind has been more of an object than the scientific side of medicine today. We ought to recall that it is not diagnosis alone that patients ask for, nor to them does it seem to be the most important point. Relief is what they come to us for. If we can administer the proper and effective means for this they will come again. Nor should we continually make manifest to every one of these people too much pathology, too much doubtful prognosis (as related to dire consequences), nor too much scientific means of diagnosis.

Oftentimes, too, many methods that are applicable to treating slight ailments will be found serviceable in treating more severe ones. A patient does not care to come to our offices and have us tell him that there is nothing wrong with him. We must relieve the slight indisposition and add to his comfort. Possibly, or probably, we will not be able to tell just why such a condition exists. Empiricism (and much treating is empirical) is oftentimes a valuable teacher (being a good or bad one, like all experiences, depending largely on previous good or bad training and personal good or bad experiences) and it will aid us to alleviate these slight ailments. It is doubtful if any of us can tell just what change takes place in the stomach when some article that has been eaten has upset it. Possibly that article has not done so at all, but if the belief is that it has, the stomach will be upset, and that condition must be relieved. Possibly we call it an idiosyncrasy and advise the taking of a proper eliminative and suggest abstinence, but, if we depend on a diagnosis of the pathologic condition caused by that article and idiosyncrasy for our idea of alleviation, we would be sadly at loss for a proper treatment.

The object of these lines is to call attention, for a few moments, away from the heavy scientific side of our profession to the more practical (would that it were also true to say the more simple) side of our work, and to indicate the necessity as well as the (to us) monetary profit in giving proper and careful attention to these ailments,—not neglectfully considering the possible graver indications of the symptoms. One more thing we would suggest. Should the physician himself be the subject of any ailment, he should endeavor to be relieved of that, or at least avoid carrying it to his office or the sick room. Patients who are depressed can only be made more so by the appearance of illness in one on whom they are leaning for relief. In future issues we will endeavor to speak, editorially, of a few of these slight ailments.

THE WASHINGTON EXAMINING BOARD.

Although attacks are made from time to time on the principle of the State examination, we believe it wise and useful so long as no National standard of medical requirements exists and there remains such a diversity of legal conditions in the different States. A Medical Act and State examination are matters of self preservation. In order, however, to secure the respect of the public and maintain a reason for its own existence, such a Board should exhibit due consideration for the rights of those persons over whom it exercises jurisdiction. Otherwise it will soon come into disrepute and its efficiency as an institution be dissipated. It should ever keep in mind that it is the servant and not the master of its creator.

To one familiar with the course pursued by the Washington Board during the past two months, it appears that the above facts have not been observed. Early in January over eighty applicants came before the Board for the purpose of passing an examination to obtain a license to practise in this State. These physicians expected and were entitled to receive information, within a reasonable time, of their acceptance or rejection. At the end of six weeks they were still awaiting this information and, according to the Medical Act, were not yet permitted to begin practice. Repeated inquiries revealed the fact that certain members had not yet reported the markings on their papers. Such delay on the part of any examiner is certainly inexcusable and culpable. What right has one individual, with no adequate excuse, to cause the loss of time and money of eighty others, for a period of several weeks?

It is stated that a majority of the Board reported their results, at the end of two weeks. If an examiner is so pressed with practice that he must thus ignore the duties of a public officer, let him resign at once. On the other hand, if indifference, neglect or excessive appreciation of his own personality persuades him to exercise such gross injustice to others, his resignation should be peremptorily demanded and his place filled by a more worthy man.

A suspicion of unfairness in connection with these examinations reflects not only on the Board itself but on the State. Nothing will so effectually produce a revolt against the State examination and its abolition, thus opening the door to unlicensed quackery and the incompetent. We commend the situation to the Governor with the earnest hope that he may hereafter appoint to the Board only men of known ability and fairness of purpose, whose actions in these respects may be above criticism or reproach.

THE STATE ASSOCIATION MEETING FOR 1904.

The Washington State Medical Association will hold its annual meeting at Seattle, July 12, 13 and 14. The Committee of Arrangements aims to make this one of the most successful and interesting meetings in the history of the Association. A letter of information has been sent to each member, who is urged to be present in person and, if possible, to prepare a paper for presentation. A successful session or otherwise rests chiefly with the members, more so than the committee. How much value will be found in the program depends upon the readiness with which they respond to the request for a part in it. Already a number of papers have been promised by well known members of the society, and it is hoped others will respond at an early date. It is expected that Dr. Mayo, of Rochester, Minn., will be the guest of the society from the East. His work and writings are so familiar to us all that no further introduction is necessary. More detailed information concerning the meeting will be given from month to month.

MEDICAL NOTES.

The Legal Status of the County Health Officer.—The friction occurring in some instances between city and county health officers will be removed, and their relative authority is clearly stated, by the following quotation concerning the opinion of the attorney general:

"The attorney general holds that while the law of 1903 makes no reference to the previous statute of 1893, which gave quarantine powers to the city health officer, it was not the intention of the legislature to grant concurrent authority of city and county, and that the later law must be followed. Cities of the first class, however, are excepted in the law of 1903.

"In declaring and maintaining a quarantine of contagious diseases in all cities other than those of the first class, the county physician has exclusive authority. While this duty has heretofore generally been taken up by the city health officers, at the expense of the city, the attorney general holds that the law of 1903 places this authority in the hands of the county officer, chosen by the county commissioners sitting as a board of health.

"There is already some discussion as to whether the act of 1903 does not lay the city health officers in cities of less than the first class on the shelf altogether, giving the county absolute control and responsibility of the health of the cities, but the opinions of the attorney general shed no light on that phase of the question, it not having been brought up at this time.

"The direct result of the law, so far, at least, will be to throw the expense of maintaining quarantines upon the county and relieving the cities."

Canadian Medical Association.—The city of Vancouver, B. C., will have the distinction of entertaining the Canadian Association which holds its annual session at that city, beginning August 23. Dr. Mayo Robson will deliver the address on surgery. Dr. William Osler will also be present and have a prominent part in the program. In addition to listening to these distinguished men, it will be an exceptional opportunity for the profession of the Northwest to meet and hear some of the well known physicians of Canada. In arranging to attend medical conventions during the summer, let us not forget this. We shall make further announcements concerning the meeting in later issues.

Merger of Two Medical Journals.—At the beginning of this year the *International Medical Journal* suspended publication, being consolidated with the *Archives of Pediatrics*. Presumably the interests of both are conserved, as thus one strong and able journal is added to another established and well known publication. The former will be remembered as a clean journal of high standard and as such we regret its suspension; we wish continued success and prosperity to the latter.

Multnomah County Medical Society.—At its annual meeting the following officers were elected for the ensuing year: President, A. Tilzer; vice-president, J. W. Morrow; secretary, T. Victoria Hampton; treasurer, Florence S. Manion; custodian of papers, J. T. Wales.

Annual meeting of Pierce County Medical Society.—At the annual meeting of the Pierce County Medical Society, held at the Tacoma Hotel parlor on Jan. 29, the following officers were elected: President, Dr. Quevli; vice-president, Dr. Swearingen; secretary and treasurer, Dr. A. de Y. Green. A large number was present and left feeling elated over the flourishing condition of the society. The retiring officers were the recipients of warm appreciation and high praise for the successful year just past.

TO OUR READERS AND CONTRIBUTORS.

Hereafter this journal will be issued on the 10th of each month. All material for publication must be received by the first day of the month. Articles will be illustrated by half tones or etchings when accompanied by photographs or drawings for the same. Reprints of contributed articles can be obtained at the cost of publication, from the Metropolitan Press, publishers of the journal. A limited number of additional copies of the journal will be supplied to contributors.

REPORTS OF SOCIETY MEETINGS.

KING COUNTY MEDICAL SOCIETY.

President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

The first regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce on the evening of February 1, 1904, President Heg being in the chair. Thirty-five members and visitors were present. Dr. A. B. Kidd was elected to membership.

On request of the President, Dr. Eagleson gave the final report of the committee on the meeting of the American Medical Association, stating that the Portland City and County Medical Society would put forth its best efforts to secure the meeting for their city and that this society would, therefore, extend its assistance to the Portland brethren to secure the meeting for the Northwest and, if successful, to make the meeting a success.

Dr. Eagleson made a statement that Mrs. Maynard, widow of the first practising physician of Seattle, now over ninety years of age, is helpless and destitute. It seemed fitting that this society should aid in supporting her declining years. After discussion of a favorable nature, the President appointed a committee, composed of Drs. Eagleson, Sweeney and Randall, to report on the matter at the next meeting.

The President called attention to the fact that the constitution of the State Association makes the county society, where the annual meeting is held, the committee of arrangements. On motion of Dr. Smith, the President was directed to appoint such a committee of five members. He stated the membership of the committee would be announced at the next meeting.

PATHOLOGIC CASES.

Gastro-enterostomy for Cancer of the Stomach. Dr. Smith presented a specimen with the following history. A man of sixty years consulted him about the middle of November, stating that he had had an irritable stomach for twenty years. The history suggested cancer of the stomach, which was emphasized by a test meal that gave an absence of HCl. The washings were accompanied by blood and gave a peculiar, sickening, mousey odor. The blood presented 55 per cent. hemoglobin, 4,700,000 red cells and 13,000 whites. No tumor was palpable; there was no pain and rarely vomiting. Operation was performed December 4. Cancerous masses were recognized along the lesser curvature and under the liver, about gall bladder. There was induration about the pylorus. The only operative procedure that seemed to promise any benefit was a gastro-enterostomy which was done by aid of the McGraw ligature, on the posterior surface of the stomach. Owing to the fixed position of this organ the wall could be drawn out only sufficient to make an anastomosis a little more than an inch in length. The patient did well for a time, taking and apparently digesting sufficient food. At the end of two weeks he emaciated and died in a few days, apparently of malnutrition. The autopsy showed the whole liver a cancerous mass, the pancreas studded with nodules, the stomach adherent to the left lobe of liver and involved with it in a friable mass. On opening the stomach the union between it and the gut were seen to be perfect. The elastic ligature was found and now shown, tightly knotted, attached to a fine strand of tissue at the edge of the opening.

Cancer of the Rectum. Kraske's Operation. Dr. Smith also exhibited a cancerous mass, removed from the rectum according to the Kraske operation. A woman, of fifty-two years, had an operation for hemorrhoids about two years ago. About that time she began to complain of pain in rectum, an annoying, bloody and more or less foul discharge. All these symptoms had become marked in recent months. The doctor saw her in consultation with Dr. Holmes, about the middle of November, when the diagnosis was made of cancer. The operation was performed early in December. The coccyx was removed, also a portion of the left side of the sacrum, sufficient to reach the tumor, which was so situated that the finger in the rectum could be inserted above its upper border. The gut was severed about one and one-half inches from the anus, and again a half-inch above the upper edge of the tumor, which was two and one-half inches in extent. An attempt to bring the upper end through the anus was attended by so great tension that it was anastomosed to the lower segment. The whole site of operation became infected, and at the end of ten days, the anastomotic area sloughed out. After considerable additional sloughing and much discharge, the wounds are nearly healed and the patient doing well.

Dr. Read commented favorably on the operation with the McGraw ligature. He was present at the above operation and described the procedure as being rapid and simple.

PAPERS AND DISCUSSIONS.

Leprosy in the Sulu Archipelago. Dr. J. W. Amesse, of the U. S. Marine Hospital Service, read this paper, outlining his experiences and observation with this disease in the Philippines. He gave the history in the islands, citing illustrative cases and giving notes of interest. He described the native mode of treatment and their superstitions concerning the disease.

Dr. G. N. Macridakes presented an abstract of an article in a recent Greek journal, describing Lepra leontina and pointing out its diagnosis from Acne rosacea, with illustrative cuts.

Dr. Redon said he had seen a few sporadic cases. As to etiology, the fish theory was discredited by most authors. The disease appears among so many people who do not eat fish. Besides, the bacillus of leprosy is not found in the fish eaten. He had seen a patient with tubercular leprosy going about the city, the Hansen bacilli swarming in the tubercles and nasal discharge. Some Greek writer has said that syringo-myelia, progressive muscular atrophy, Raynaud's disease and other diseases of the nervous system are types of leprosy. But he has advanced no proof nor given a satisfactory theory.

Dr. Macridakes said that, in the island of Crete, there are about 3000 cases, in a population of about 3,000,000. There it is claimed to be due to eating olive oil in excess, of which some people consume three or four pounds daily. The government seems unable to check the disease and the patients move about from place to place. Children from leprous parents do not necessarily exhibit the disease.

Dr. Miles remarked that we are liable at any time to see these cases in Seattle, and we should be prepared to recognize them. He described several patients he saw at one time in Philadelphia. He asked why do not the Aleuts in Alaska have the disease. They live entirely on fish and seal oil. This would seem to argue against the fish theory.

Dr. Raymond described a patient he treated in Seattle several years ago, a Finn, who could speak no English. At first he was supposed to have syphilis. Later the bacilli of leprosy were found in myriads in the ulcers of the legs. He presented the leonine facies, the larynx and eyebrows had disappeared. Hutchinson believes the eating of fish to be the only cause of the disease, and he seems to have followed the theory to completion in many cases.

Dr. Tripp stated there were twenty-five or thirty patients in Minnesota, all of whose addresses were kept by the State Board of Health. No attempt is made at treatment. They are all adult Scandinavians.

Dr. Sweeney mentioned reading an article in a Geographical Tropical Journal, stating that Manson claimed the disease was transmitted by mosquitoes. They bite subjects of the disease. After development in their bodies the eggs are deposited on drinking water. These contain spores of the bacilli and are transmitted to those drinking the water.

Dr. Amesse claimed the disease is surely infectious, and is thus transmitted. He cited the case of a wealthy planter in Hawaii who, one day grasped the hoe from the hands of an employe whose work was unsatisfactory, and used it vigorously enough to raise blisters on his hands. Later he learned the man was a leper. In about two years leprosy appeared on one hand. In spite of having the arm amputated, the disease continued and now he is a resident of the leper colony, well advanced in the disease.

The second regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce on the evening of February 15, 1904, President Heg being in the chair. Twenty-five members and visitors were present. Dr. H. G. Lazelle was elected to membership.

In behalf of the committee, to which was referred the matter of rendering assistance to Mrs. Dr. Maynard, Dr. Sweeney recommended that the Society appropriate the sum of $5 per month to be added to the fund for this purpose. The motion prevailed.

The President announced the following Committee of Arrangements for the coming meeting of the State Medical Association: Drs. C. A. Smith, C. W. Sharples, I. A. Parry, G. S. Peterkin and G. W. Hawley.

Dr. Smith moved that the chair appoint a Membership Committee of five, who should institute a systematic effort to bring into this Society the eligible physicians resident in the county. The motion was adopted and the President stated he would announce the membership at the next meeting.

PAPERS AND DISCUSSIONS.

Symposium on Typhoid Fever. Etiology and Pathology, by H. G. Lazelle; Diagnosis and Prognosis, by R. M. Stith; Treatment and Prophylaxis, by E. E. Heg.

Each writer presented a thorough, scientific and modern description of the branches of the subject assigned to him, covering the ground as presented by the latest authorities. Details were given of modern methods of diagnosis and differentiation from other diseases. Under treatment, a more liberal diet was recommended than that of milk alone. Special reference, under prophylaxis, was made to the necessity of reporting cases to the Board of Health and thus leading up to real prophylaxis.

Dr. Edson thought that tympany is a very unfavorable condition and, in the presence of hemorrhage, tends to aggravate the condition by stretching the ulcerations. Therefore the administration of opium may be contraindicated as tending to favor this tympanic state, by virtue of its paralyzing effect on the bowels.

Dr. Smith commended the excellent work displayed in all the papers. He remarked that, the longer one practised, the more he is impressed with the fact that almost any disease may be confounded with typhoid. This error may be made by the most experienced. He cited an illustration. Although it may not be wise to feed a patient alone on milk, he doubted whether so liberal a diet as recommended by Dr. Heg would be accepted by many. He referred to a physician who permitted an unlimited diet and stated he never lost a case, a claim that would be received with question. He approved Dr. Heg's emphasis of the importance of reporting typhoids to the Board of Health.

Dr. Peterkin thought that, in the future, attention would be paid to differentiation of bacteria and their effects on the human economy. By this means we may be able to anticipate the actions of these germs and prepare for them. It is a question with him whether there is a distinction in fact between the colon and typhoid bacilli. The one may be but an evolution from the other.

Dr. Harris referred to the existing epidemic in Tacoma, relating the experience of a medical friend in that city who had treated about fifty cases. Half he had treated with acetozone. He had found no difference in the character nor course of the disease in these from those without it. This friend had a case of severe hemorrhage, whom he treated with adrenalin chlorid, with the result of causing the hemorrhage to cease, whether really due to this agency or not, he would not say. He had used it other times, with a similar apparent result. The doctor thought it well to keep this remedy in mind and that it might prove useful in these cases.

Dr. Read commended the paper as covering the whole field of the disease. He would especially endorse Dr. Heg's contention for the reporting of cases to the health office. It is very important to discover and abate the cause of an epidemic if possible.

Dr. Johnson described an epidemic in a small town on the Great Northern, in Montana, where about half the residents had the disease. It was discovered that the water supply was contaminated by a case that had occurred two years previously along the stream, from which the water was obtained. He mentioned the use of guiacol as antipyretic, with favorable results.

Dr. Pontius related an epidemic occurring in Pennsylvania some years ago. There were about 200 cases, with one death, the man having received practically no care. They were all treated with phenacetin and all received full diet.

Dr. Cunningham inquired as to the role played by oxygen in the treatment of the disease, of which much has been said in the papers, in connection with the illness of a distinguished patient.

In closing, Dr. Heg said he thought tympany had little to do with hemorrhage. It is most important to prevent peristalsis, which is the chief agent in favoring hemorrhage, and this is accomplished by quieting this action with opium. He did not wish to be understood as favoring an indiscriminate diet, but a liberal one. In Cuba they were compelled to feed typhoids hard tack, bacon and coffee, the only available food. He thought the only function of oxygen is as a heart stimulant, and simply sustains life a few hours.

WHATCOM COUNTY MEDICAL SOCIETY.

President, D. E. BIGGS, M. D.; Secretary, W. N. HUNT, M. D.

The regular monthly meeting was held Monday evening, February 8, 1904, in Odd Fellows' building, Bellingham, Wash.

Several matters of local interest were discussed, after which the program of the evening was taken up.

PAPER AND DISCUSSION.

Syphilis in Relation to Its Effects on the Central Nervous System. Dr. A. Macrae Smith read this paper, reporting in detail four cases illustrating some of the varied symptoms and lesions of this disease. Two of the cases were followed by autopsy. The doctor gave it as his opinion that endarteritis was least amenable to treatment and the gumma most so, of the common syphilitic lesions of the brain and meninges.

Dr. Holt gave an informal talk upon syphilitic eye lesions, referring especially to interstitial keratitis and plastic iritis, which he said were, in a very large proportion of cases, syphilitic in origin.

A general discussion followed.

The Society adjourned to meet the second Monday in March.

RECENT PROGRESS IN MEDICINE AND SURGERY.

OBSTETRICS AND GYNECOLOGY.

Edited by
P. W. Willis, M. D.; W. A. Shannon, M. D.

1. The Treatment of Cancer of the Uterus by Roentgen Rays. 2. The Etiology of Eclampsia. By John G. Clark, M. D. From an address in obstetrics delivered before the Pennsylvania State Medical Society, September 22, 1903. Univ. of Pa. Bulletin, Nov., 1903.

He sums up the present status of the x-ray in the treatment of cancer of the uterus from a careful review of the American authorities, who, he says, are the leaders in this line of work. He first calls attention to the pathologic fact that in cancer there is proliferation of the epithelium at the expense of the connective tissue. In regard to the manner in which benefit is secured by the x-ray there are differences of opinion, some believing that there is a direct destructive action on the cancer cells; others that it causes increased functional activity of the connective tissue. He quotes from Skinner the following theories in regard to the curative factors of the x-ray:

"1. Stimulation of the reparative functions of the tissues.

"2. Selective destructive power of the rays for aberrant tissues of low vitality.

"3. Destructive power over the cancer germ, while increasing the resisting power of the tissues.

4. Reversion of the new growth to it's primitive form."

He somewhat questions No. 3 because the existence of the cancer parasite has not been proved.

He quotes other authorities who claim that the important action is upon the sensory or trophic nerves. He himself believes that it is more likely due to the stimulation of the invaded tissue. He also believes, however, that there is some destruction of the cancer tissue as shown by local necrosis, and some authorities believe that a serious toxemia may develop from absorption of this necrotic tissue where the x-ray is used too vigorously. He gives a strong warning against the employment of the x-ray treatment in operable cases, but believes a trial should be made on those which are inoperable or recurrent.

He summarizes his conclusions from a review of the American literature and from his own experience as follows:

"1. No operable case of cancer should ever be temporized with by this new agent, for as yet our knowledge of its value is too limited to justify the abandonment of operative measures, which, although far from satisfactory, unquestionably offer a definite percentage of cure.

2. As yet no local therapeutic agent has proved of the least value in even ameliorating symptoms in inoperable or recurrent cases.

3. To this class of cases we hold out a remote hope of cure, and certainly a definite probability of relief of pain, discharge, and other disagreeable symptoms from the use of the Roentgen rays.

4. As yet it is impossible to venture a positive opinion as to the ultimate value of this treatment in cancer of the uterus but, as it offers some hope which can be said of no other remedy, it is at least our duty to fully investigate its merits and thus determine its value as a curative or palliative treatment."

The Etiology of Eclampsia.—He first mentions the pathologic changes found in fatal cases. These consist of arterial and venous thrombosis in the kidney, liver, heart, lungs, brain, pancreas, and adrenals, with associated necrosis, hemorrhage, and parenchymatous degeneration. On account of these changes being general, affecting all the organs similarly, a doubt has been expressed as to the kidneys being the primary cause.

He then gives the various opinions and theories of different investigators and finally concludes this very interesting study as follows:

"This review of the latest investigation leads to the conclusion that puerperal eclampsia arises from a defective excretory power of the mother, usually referable to the kidneys, but that the actual toxin is a fetal product, the added stress of which upon the defective eliminating powers of the mother precipitates the eclamptic attack."

WILLIS.

Retrodisplacements of the Uterus. (By J. M. Baldy, American Medicine, December 26, 1903.)

Baldy considers retrodisplacements of the uterus one of the legacies of the dark ages. He says, "Retrodisplacements of the uterus are usually coincident with other lesions, and when such is the case, the symptoms almost universally come from the associated disease." The symptoms usually supposed to be caused by displacements are usually due to inflammatory disease of the pelvis. The ovaries are very commonly the seat of disease.

The treatment will vary with the pathologic condition and a certain number of cases require that the uterus be held forward. When this is the case he believes that the best method is the intra-abdominal shortening of the round ligaments. The advantage of this over the Alexander's operation is that it does not weaken the inguinal canals and there is no chance of failure in performing the operation, and over the ventrosuspension in that there is no unnatural attachment and the uterus is not raised from the pelvis. He believes that the pessary seldom does good and often does harm. WILLIS.

One Thousand Cases in Students' Out-door Obstetric Practice. (By Dr. John F. Winn, in the Jour. of the Am. Med. Assn.)

He gives his report of the first series of 1000 cases in the out-door obstetric department of the University College of Medicine. After describing the aseptic precautions taken by the students in attendance upon these cases, and referring to the fact that the patients represented, for the most part, the extremely destitute portion of the white and black population and consequently that the work was prosecuted amidst the most unfavorable and unhygienic surroundings, he asks the question, why is the death rate greatly lower than that recorded in private practice and amid ideal sanitary environments?

Out of the 1000 cases reported there have been but five deaths. From his report he draws the following conclusions:

1. The results are confirmatory of Kroenig's statement that the vagina of a pregnant woman is free from pus-producing bacteria.
2. Thorough and continuous disinfection of hands and external genitalia are the chief safeguards against infection.
3. The unhygienic suroundings in the homes of the poorer classes must be considered as minor factors in the causation of sepsis. They become operative only when scrupulous care is not observed with regard to vaginal examinations.
4. Not only is the puerperal morbidity and mortality among outdoor clinics greatly below that in private practice but it would appear that this class of patients is endowed with powers of resistance not found in the higher walks of life.
5. Nature has her own time for separating and expelling the placenta, as indicated by a signal, easy of recognition.
6. Any method designed to excite uterine contraction before Nature indicates that the placenta is ready to be cast off must be regarded as precipitate, and not in accord with natural processes.
7. Just in proportion as the genital tract is regarded absolutely as a *noli-me-tangere*, after the child is born, will the puerperium be marked by fewer deviations from the normal. SHANNON.

The Causation and Treatment of Eclampsia (By Dr. A. Lapthorn Smith, Annals of Gynecology and Pediatry, Jan., 1904.)

The writer discusses interestingly his theory of the cause of this condition. He holds that eclampsia is due to anemia of the corpora striata of the brain or such other parts of the brain centres as control muscular movements. This anemia, he says, is brought about by a spasm of the arterioles which carry blood to the part; that this spasm is not limited to these arterioles alone, but that every capillary in the body is probably equally affected by the spasm, so that, as the quantity of poisonous material, not necessarily urea, accumulated in the blood increases, the arterioles of the kidneys contract tighter and tighter, until no more blood can get into them and the spasm-exciting material rapidly increases in a vicious circle. As the spasm-producing toxins increase, the arterioles of the brain tighten up, causing disorders of vision and headache, and when the quantity of spasm-producing material has increased still more the circulation of the blood through the kidneys comes to a stop also, and the patient loses consciousness and convulsions begin. The heart acts in correspondence with the vasomotor system so that the same poison, which causes the spasm of the arterioles of the kidneys and of the brain, also causes excited action of the heart which is increased still further by throwing of all the peripheral blood into the large veins and arteries, as is evidenced by the pulmonary obstruction. He claims that with this theory of spasm and this alone can we answer any questions concerning the treatment.

He claims that the best treatment is the one that will in the quickest possible manner put an end to that fearful vasomotor spasm and allow the blood to rush into the brain and kidneys so that the patient may regain consciousness and the kidneys begin to eliminate the toxin which causes the spasm. His treatment is a half or three-quarters of a grain of morphin given hypodermically, followed in five minutes by a hypodermic of ten minims of Tincture of Veratrum Viride repeated every ten minutes until convulsions stop or the pulse comes down to forty. Then give a quart of salt solution by enema. No chloroform will be needed and no chloral, which latter drug, he claims, has caused so many deaths ascribed to other causes. He claims he has not heard of a single case of eclampsia that died, treated with morphia and veratrum but without chloral or chloroform. He firmly believes that the administration of a pound of chloroform in twenty-four or forty-eight hours, at the end of which time the woman died, is enough to cause her death without eclampsia. He quotes Dr. De Cotret, director of a lying-in hospital in Montreal, who says he has not had a death from eclampsia in the institution since the veratrum treatment was instituted and quotes forty consecutive cases without a single death. SHANNON.

Fetal Heart Murmurs in Gravida with the Report of a Case (By Horace G. Wetherill, M. D., Am. Journ. of Obstetrics, Jan., 1904).

The doctor reports a case of fetal heart murmur in Gravida. In making an examination of the heart sounds of the fetus in utero he detected a systolic murmur which was clear, pronounced and unmistakable, from the first. It was heard two inches below and to the right of the umbilicus of the mother and was audible over an area of about three inches of the abdominal wall. The child when born weighed five pounds and an examination of its chest corroborated the diagnosis of systolic murmur previously made. SHANNON.

Abdominal Versus Vaginal Hysterectomy in Cancer of the Uterus (By Jno. B. Deaver, M. D., Journ. of Obstetrics, Jan., 1904).

The writer begins by endeavoring to impress upon the general practitioner the fact that irregular bleedings from the uterus, whether before, during or after the menapause, should be viewed with suspicion and thoroughly investigated. Many of the cases of supposed hemorrhagic endometritis, with a malignant family history would be better for a complete hysterectomy.

He is strongly opposed to vaginal hysterectomy for carcinoma of the cervix uteri, except in the presence of obstacles necessitating such a course. It is his practice to do a complete hysterectomy by the abdominal route, in fundal as well as in cervical carcinoma. He claims the vaginal operation offers no advantage over abdominal section when the latter is properly and intelligently performed, and suffers from the imputation of being an incomplete operation, dangerous to the ureters and liable at any time to give rise to severe secondary hemorrhage. He says the abdominal operation offers an increased space for necessary manipulation, greater security against hemorrhage and less risk of injuring the ureters. In abdominal hysterectomy we are better able to keep beyond the area of diseased tissue, a larger portion of the broad ligaments, together with their lymph channels, can be excised and individual glandular enlargements noted and removed.

In performing abdominal hysterectomy for carcinoma of the cervix he first curetts the cancer area and cauterizes with pure carbolic acid and then recleanses the vagina thoroughly. He does not make a median incision in the abdomen but prefers to incise through either rectus muscle close to the median line, thus avoiding hernia, one of the so-called disadvantages of the abdominal route. SHANNON.

DERMATOLOGY.

Edited by

L. H. REDON, M. D.

Potassium Permanganate in the Treatment of Lupus.—The Therapeutic Gazette, Nov., 1903, gives the following excerpt of Hall-Edwards' paper, printed in the British Medical Journal of June, 1903, concerning the use of this salt in the cure of lupus:

During his observations of a large number of cases treated by means of the x-ray, the author has tried the action of a number of drugs in conjunction with the rays. Some have been used for the purpose of bringing about a more speedy reaction, others with the object of limiting the dermatitis. During these experiments he was early struck by the good effects produced by potassium permanganate, not only as an adjunct to x-ray treatment, but in clearing up patches left after the administration of the rays.

After having used the drug for a considerable length of time, and in a variety of ways, he discovered that the treatment of lupus by this means was not new; and his attention was drawn to an article in the *British Medical Journal* of April 5, 1902. It appears that the use of this drug for the treatment of lupus bulgaris and erythematosus was first suggested by Butte. In the article mentioned Dupuy gives the results of his observations on a number of cases treated by Butte's methods. Butte used a compress of a two per cent. solution of potassium permanganate, which was applied for twelve or fifteen minutes daily, for about a fortnight; or in non-ulcerative patches, the powdered drug was spread over the part with a spatula, a piece of dry absorbent wool applied, and the whole left on for a quarter of an hour. This latter method is somewhat severe, and produces a considerable amount of inflammation. Dupuy maintains that the action of permanganate is more rapid than scraping, and the resulting cicatrices are softer, flatter and less likely to contract than those following other methods. One disadvantage (he says) is that the tissues are considerably stained.

After trying many methods the author has now for some time used this with such good results that he makes no apology for bringing it before his readers. He uses a saturated solution of the salt, which is made by dissolving a dram in an ounce of distilled water. In non-ulcerative cases he first washes the patch with carbolic or ichthyol soap, and afterwards wipes it over with a pledget of cotton-wool, moistened with methylated spirit. When dry he applies the solution of potassium permanganate with a brush. In cases covered with crusts the surface is cleaned as well as possible without removing it, and the crusts themselves are saturated with the solution. The applications are repeated every day or every other day until relief is obtained.

In many cases of lupus treated by the x-rays, the centre of the patches rapidly get well, whilst the edges continue to spread slowly. In these he has met with his best results. In most of these cases he has continued the x-ray treatment in addition to the application of permanganate, so that it is difficult to judge the effects of either method alone. Recently, however, he has treated several cases with permanganate alone, and has been surprised at results obtained. In several typical cases of large areas of lupus, where the centres of the patches have undergone cicatrization, whilst the edges have been marked by a thick line of dry crusts, two applications of the paint have caused the crusts to fall off, leaving a dry, healthy scar behind them, the active points remaining being painted over and over again until they finally disappear. The potassium permanganate treatment appears to have little or no effect upon those indurated, shiny, non-ulcerative, slow-growing patches, which are so difficult to treat either with the light or the x-rays. No staining has resulted from this method of treatment. REDON.

Syphilis and Divorce. By Prince A. Morrow, M. D., Med. News. Dec. 12, 1903.

The introduction of syphilis into marriage entails not only physical damage to the health and life of the wife and children, but it involves in married life by one partner to the other, or even the exposure of one partner to the contagion from the disease may affect (1) contracts to marry, (2) annulment of the union, and (3) divorce.

It is of the utmost importance that the physician should have an understanding of the law of marriage and divorce as applied to venereal diseases. The mere existence of venereal disease in one partner, or even its communication to the other, does not, per se, constitute sufficient ground for divorce. There must be certain concurrent conditions of an aggravating character. While syphilis is not specifically mentioned as a cause for a divorce in the statute books, actions for divorce may be instituted upon the ground of "cruelty," as it is generally held by the American and English courts that the communication of this disease constitutes cruelty, which is a statutory ground for divorce.

Contract to Marry.—The existence of venereal disease in either party to a contract to marry is sufficient ground for the other party to refuse to fulfill the engagement, and therefore constitutes a valid defence in a breach of promise suit.

As a Ground for Annulment.—The existence of a venereal disease in either party at the time of the marriage may render the marriage voidable. The annulment of the union in such cases would seem to be based upon the rule of the law which recognizes permanent and incurable impotency sufficient ground for divorce.

Divorce.—To constitute a ground for cruelty it is usually required that the disease should have been actually communicated to the complainant; that the complainant should have been ignorant of the existence or nature of the plaintiff's disease at the time of its communication, and that the defendant should have infected the petitioner, knowingly and wilfully.

Under the present conditions of the law the physician should advise his patient that syphilis should never be invoked as a cause of action for divorce unless it constitutes the chief and only phase of cruelty that can be alleged. The charge of infidelity, if it can be sustained, should always be the preferential plea. The woman who seeks a divorce upon the plea of syphilitic infection by her husband should be fully informed of the ordeal before her. She must prove (1) that her husband has syphilis; (2) that she has syphilis; (3) that the syphilis of her husband is the origin of her own. As the law now stands there is no civil or penal responsibility imposed upon the husband for the transmission of syphilis in the marriage relation.

In regard to the physicians' line of conduct in the matter of syphilis and divorce it is rarely advisable that he should appear in the interests of his patient. Especially should the attending physician not give a letter or certificate that the individual has syphilis and that he is treating him or her for it. In the first place, he may be treating both husband and wife, and should be give a certificate he would betray a secret confided to him. In the second place, certificates of this character are lookea upon with suspicion and have even been rejected by the courts.

REDON.

PATHOLOGY AND BACTERIOLOGY.

Edited by

R. M. STITH, M. D., SEATTLE. R. D. WILSON, M. D., TACOMA.

Puerperal Sepsis and Its Treatment by Iodine. By William R. Pryor, M. D., N. Y. and Phila. Med. Journ., Jan. 23, 1904.

All cases of puerperal fever are not septic, about 25 per cent. being septic, 75 per cent. non-septic. Puerperal sepsis is due to the same bacteria as cause sepsis elsewhere. Microscopical examination alone will determine the exact nature of a given case. Duebendorfer (Doederlein's clinic) showed that the vulvae of pregnant women harbored streptococci in 1 per cent. colon bacilli 48 per cent. Therefore a microscopical examination of the material upon the vulvar napkin, after delivery, will not determine the nature of an infection.

In the vagina, Walthard found streptococci in 27 per cent.; Goenner 5 per cent.; Duebendorfer 36 per cent; Koblank 10 per cent.; Stahler and Winkler 23 per cent. (one series) 50 per cent. (another series). On the contrary Kroenig but once in 167 cases, John Williams not once in 117 cases. Examination of vaginal discharges is not a safe indicator of the nature of an infection. The only sure method is an examination of material from the uterine cavity, obtained by the Doederlein method. Franz, in 262 puerperal cases (afebrile), found germs in the uterine cavity in 57. From another series of 120 cases, he obtained germs in 71; streptococci 9 times; staphylococci 12 times; and the colon bacillus once. These findings are confirmed by some and denied by others. The differences may be due to differing points of technic. Those rarely finding germs use solid media, the others use liquid media in excess. The genital tract of pregnant women may occasionally harbor germs without detriment. When are the germs innocent, when virulent?

Walthard finds pyogenic cocci may be in the uterine cavity and act as saprophytes, lying upon the surface of the endometrium and not penetrating into its substance, producing no clinical disturbance unless the drainage has been interfered with or the endometrium subjected to trauma, when they may exhibit extreme virulence.

All puerperal sepsis cannot be charged to unclean examining fingers, as Ahlfeld and Walthard have reported many fatal cases in which no vaginal examinations were made. Stoltz has found more cocci in the uteri of the unexamined women than the examined. Sticker, in Kuestner's clinic, has proven that sterile rubber gloves have not altered puerperal morbidity, but it is largely governed by the number of examinations before and during labor.

In 72 per cent. of cases any substance, penetrating from vulva to vagina, will carry germs into the vagina, for in just that proportion are germs present in the vulva. In about 60 per cent. of the cases of puerperal sepsis the infections are mixed—saprophytes, streptococci and colon bacilli. The saprophytes and colon bacilli possess poor penetrating power. So, when the fluid from the pelvis is examined, a pure culture of streptococci is found (contrary to most writers on obstetrics). Pryor does not believe that, in the majority of cases of puerperal sepsis, the infection remains localized in the uterus; also that the colon bacillus is not virulent unless associated with cocci or the tissues greatly damaged. STITH.

BOOK REVIEWS.

Edited by

KENELM WINSLOW, M. D.

The Blues (Splanchnic Neurasthenia), Cases and Cure.—By Albert Abrams, A. M., M. D. (Heidelberg), F. R. M. S., Consulting Physician, Denver National Hospital for Consumptives; The Mount Zion and the French Hospitals, San Francisco; President of The Emanuel Sisterhood Polyclinic; formerly Professor of Pathology and Director of the Medical Clinic, Cooper Medical College. San Francisco. In cloth, 240 pp, illustrated, $1.50 postpaid. E. B. Treat & Co., 241 W. 23d St., New York.

In this book we find much that is original in thought and investigation. The chief motive of the work is directed toward a solution of abdominal troubles resulting from neurasthenia. The writer attributes the symptoms largely to congestion of the intra-abdominal veins, due to impairment of the abdominal muscles from numerous causes. He elaborates his theory in a thoroughly scientific spirit and adduces much experimental and clinical evidence to support it. The practical value of the book is also great as the methods of cure, mainly through appropriate exercises, are completely and clearly detailed. In the appendix may be found a valuable contribution to the methods of exploration of the chest and abdomen, in which the value of special signs and the use of new methods are explained. Altogether the monograph will prove a valuable contribution towards a subject which is only too little understood by the general practitioner, and will also afford him much practical assistance in the treatment of these not uncommon cases. WINSLOW.

Morrow on Social Disease. The Relation of Social Diseases and Marriage. By Prince A. Morrow, A. M., M. D., Emeritus Professor of Genito-Urinary Diseases in the University and Bellevue Hospital Medical College; Surgeon to the City Hospital; Consulting Dermatologist to St. Vincent's Hospital, etc., New York. In one octavo volume of 390 pages. Cloth, $3.00, net. Lea Brothers & Co., Publishers, New York and Philadelphia, 1904.

The advent of this book marks an epoch in the educational progress of veneral prophylaxis. It is the first comprehensive treatise which has given detailed attention to the relations of veneral diseases to society and has the additional advantage of being written by a master of the subject. While the work is intended for the medical profession, yet only touching on the relation of venereal disease to society and marriage—and avoiding any technical account of the causation, symptoms or treatment of these disorders further than to make his remarks intelligible—it can readily be comprehended by any well-educated and intelligent person and should be read with profit by all teachers, professional men and college students. In regard to the Medical Secret, Morrow deplores the necessity which custom imposes that the physician cannot prevent gonorrheal patients from marrying before they are cured by warning the intended bride of the danger. Yet in some aggravated cases where the gonorrheic persists in the attempt, despite the emphatic protest of his physician, the latter may be justified in thwarting the former's designs. In case of gonorrhea in the husband after marriage, while it is the duty of the physician to shield the secret of his patient, yet he should prevail upon him to acquaint his wife of the facts that she may be properly treated—prophylactically or therapeutically. In regard to the time which should elapse after acquirement of male gonorrhea before marriage, Morrow states that on an average at least six months are required for the treatment of chronic gonorrhea, while three per cent. of these cases are incurable. Also, that victims of long continued or frequent infections should remain under observation a year after the absence of gonococci before marriage is permissible. Sterility of the male results in 25 per cent. of sterility in the female. Thus prostatitis, vesiculitis, funiculitis, orchitis, epididymitis and stricture may lead to sterility or impotence interdicting marriage. Microscopical examination of the semen is the only test for male sterility. Fifty per cent of pelvic inflammations of women are due to gonorrheal infection—according to the average of replies from thirty-five noted gynecologists—but a few low estimates reduced this average, which is more probably 75 per cent. Chancroid contraindicates marriage until the time for the appearance of secondary symptoms elapses—in case it be true chancre, from which it is impossible to always separate it. Morrow states that 70 per cent. of the women in the New York Hospital with syphilis were respectable and acquired the disease from their husbands. The physician should persuade a syphilitic husband to confess his disease to his wife; if his wife becomes infected and the husband refuses her treatment, the physician should give up the case. Ordinarily the medical man must try and treat the infected wife while keeping her ignorant of the source and nature of her disease—this, however, compromises often the dignity of the physician and results in too short a treatment for the wife.

The medico-legal relations of venereal diseases to divorce are thoroughly considered; also the various means of prophylaxis—sanitary, state, educational, etc. The writer advocates penalizing the transmission of venereal disease, and the obligatory notification to health boards of cases of venereal disease with the diagnosis and source, but omitting the name of patient. He also suggests to parents and guardians that they require the applicant for a maiden's hand to furnish a clean bill of health-certificate before permitting marriage. The question considered by Dr. Morrow's book is and always has been one of the most important whi confronts civilized mankind and the author's contribution towards the educational solution of the problem is of the greatest value. While educational enlightenment will not alter human nature nor destroy the lusts, it will remove the ignorance which becomes synonymous with sin and suffering occasioned by the social diseases, of which it is one of the most prominent causative factors. The publishers have left nothing to be desired, as the binding is pleasing and the topography and paper—with wide margins—excellent.

———————— WINSLOW.

International Clinics. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles On Treatment, Medicine, Surgery and the Specialties. By Leading Members of the Medical Profession Throughout the World. Volume IV, Thirteen Series. 1904. J. B. Lippincott Co., Phila. Price, Cloth, $2.00.

This number of the well-known publication contains many articles of great interest. Musser's Treatment of Pneumococcic Infection of the Lung contains much that is valuable and practical, and the minute details given form a distinct addition to this time-honored but not exhausted subject. The use of Subcutaneous Injections of Mercury for Syphilis, by Louis Julien, of Paris, appears to be a little too *fin de siecle* for us on this side, and his employment of subcutaneous injections of calomel as an abortive agent in syphilis before secondary symptoms have occurred—and therefore before an absolute diagnosis is possible—does not appeal to Anglo-Saxon conservatism. On the other hand, The Differential Diagnosis of Acute Abdominal Conditions, by Battle and Corner, of London, exhibits the intense and—we are tempted to say—the antediluvian conservatism of some of our confreres on the historic isle. This is not illustrated by the article, which is an exceedingly plain and precise exposition of this difficult subject, couched in language—the purity and simplicity of which is characteristic of our English cousins and which we might profitably imitate,—but in the cited statistics of three years of work at St. Thomas' Hospital, ending in 1902, we find that there were 168 cases of appendicitis admitted, and of these 59 per cent. were suffering with diffuse peritonitis. Cutting criticism is needed to overcome this inexcusable adoption of a Fabian policy in a disease possessing such uncertain and volcanic possibilities.

A suggestive and timely article on Physiognomical Diagnosis in Disease, by Sir Dyce Duckworth, recalls the wonderful development of this faculty in the late Professor Laycock, of Edinburg, who is said to be the true inspiriter of Conan Doyle's Sherlock Holmes. It is an art which, besides having much intrinsic value for the medical man, endows him with wonderful and mysterious powers in the minds of the laiety. Some Clinical Aspects of Diseases of the Kidneys, by Favill, of Chicago, is a very suggestive article and introduces cases of nephritis apparently due to toxemia of acute indigestion and followed by complete recovery. It shows the futility of a too close adherence to the anatomical basis in renal disorders. Keen, of Philadelphia, presents a model for a clinical lecture on a case of removal of one side of the pelvis and amputation of the thigh for sarcoma of the ilium, in which the operation is described and all the steps leading up to it with the reasons for its formal adoption and the precautionary measures followed. A valuable monograph is contributed by Albarran, on The Radical Cure of Prostatic Hypertrophy by perineal prostatectomy, which he has performed 35 times with only one death, which occurred some weeks after operation and could not be attributed to it. There are numerous other articles of note, but time does not permit of their notice. Suffice it to say that the Quarterly continues to hold its own and more. WINSLOW.

DR. D. S. MAYNARD

THE PIONEER PHYSICIAN OF SEATTLE

1808-1873

NORTHWEST MEDICINE

April, 1904.

DR. D. S. MAYNARD, THE PIONEER PHYSICIAN OF SEATTLE.*

By Mr. Thomas W. Prosch,

SEATTLE, WASH.

David Swinson Maynard was born in the State of Vermont, March 22, 1808. He was there reared and educated. He studied medicine under Dr. Woodward, receiving at an early age a diploma and the legal right to practice his profession. He then moved to the State of Ohio, where, in association with three other men, he established a medical school, which soon had upon its rolls the names of one hundred and fifty students. In 1829 he and Lydia A. Rickey, of Vermont, were married. Several children resulted from this marriage. Owing to his endorsement of another man's business enterprise in Ohio, which failed for $30,000, Dr. Maynard was financially ruined. Owing further to trouble in his family, he severed all relations with the East, early in 1850, and started for the Pacific Coast. His whole outfit consisted of a horse and what he and the horse could carry, including chiefly surgical instruments, medicines, money in pocket and blankets. Being strong, self-reliant, helpful, intelligent and able, he found hearty welcome among the immigrants that year crossing the plains. He attached himself to a train, among the members of which were Mr. and Mrs. Israel Broshears.

On the journey to the West the immigrants were attacked by cholera. Whole parties and families were in many cases destroyed. In other cases half the members of a train died from the malady. Wagons were abandoned for the want of drivers. Mr. Broshears was one of the unfortunates. His widow was left without help. It was impossible to hire any one. It cannot now be said what would have become of her had it not been for Dr. Maynard. He took charge of the animals, wagons and other

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*Read before the King County Medical Society, Seattle, Wash., March 7, 1904.

Broshears properties, and, driving the cattle himself, brought all through safely, arriving at Olympia in September, where he left the widow and her goods with her brother, Col. Michael T. Simmons, the well-known pioneer of 1844.

Dr. Maynard at once entered upon business enterprises. Before the year was out he had camped upon the site of the present city of Seattle while on his way to look at a reported coal deposit in what is now Snohomish County. Returning to Olympia, he entered the mercantile business. buying goods in San Francisco, speculating, and between times practicing professionally. He made the acquaintance of Chief Seattle, who, in his desire for a white trading settlement nearer his home, persuaded Maynard to come north and plant himself on Duwamish Bay. Putting all his goods into a large boat, Maynard in March, 1852, started for his new home. On the 27th he arrived at Alki Point. There he found C. D. Boren, A. A. Denny and W. N. Bell, about to remove to the eastern shore of the bay. They were pleased to have an addition to their company. All took donation claims, Maynard's being south of Yesler Way, Boren's north, then Denny's and Bell's. Having come sooner than the others, Maynard got in his own right 320 acres, the land allotted to a man under the first donation act. He got nothing, however, on account of his wife. The other men got 160 acres for themselves, and their wives also 160 acres each. Maynard settled at once on his land, building a small house at the corner of Main Street and First Avenue South, where the New England Hotel now stands. There he lived, there he opened the first store in Seattle, there he held court, there was the first election (in Duwamish Precinct, Thurston County, Oregon Territory), and there during the first year was transacted most of the business in the new settlement, destined in later years to be one of the great cities of the world.

In December, 1852, Dr. Maynard participated in the famous Monticello convention, which resolved in favor of a new territorial government and asked Congress to divide Oregon and create Columbia. As a result of this movement, Washington Territory was created by congressional act in March, 1853. Leaving Monticello, Dr. Maynard went on to Salem, where the Legislature was in session. The only representative Puget Sound had was Col. Isaac N. Ebey, of Whidby Island. Dr. Maynard had two objects in view. The first was to have the Legislature divorce him from his wife, Lydia, which, after considerable opposition from Ebey, he succeeded in accomplishing. The second object was the creation of King County. In this he also succeeded, the county seat being located upon his donation claim. The bill introduced provided for the creation of Buchanan County. It was amended by changing the name to King, in honor of William Rufus King, who had just been elected Vice-President of the United States.

On his way back to Puget Sound Dr. Maynard stopped at Olympia and there married the widow Broshears (born Catherine Troutman Simmons, in Kentucky, 1816). They arrived in Seattle, January 20, 1853, and here has since been the home of the second Mrs. Maynard for more than half a century.

In the summer and fall of 1852 Maynard employed a large number of Indians in the salmon fishery, they putting up for him eight hundred barrels of fish. Early in 1853 he engaged in the sale of town lots, disposing of many before filing the plat, and in that way doing much to establish the town upon his claim. May 23, 1853, by arrangement with Arthur A. Denny and Carson D. Boren for united action, he and they filed plats of the town of Seattle, the name being adopted by common consent of all the people then residing upon the lands about. At the same time Maynard was the town physician, druggist, merchant, notary public, justice of the peace, clerk of the court and hospital keeper, his wife being the nurse in the latter, and generally his helper in his various enterprises. He also acquired sufficient knowledge of the law to pass the necessary examination and secure admission to the bar, he being the first man so admitted in Seattle. He finally exchanged his remaining Seattle lands for the Alki Point farm of Charles C. Terry, and for a number of years dwelt there. During the Indian war of 1855-56 he was a sub-agent at Port Madison reservation, having in his charge many hundreds of neutral or non-combatant Indians, acknowledging the wise leadership of Chief Seattle.

Dr. Maynard's later years were spent quietly in the town he had done so much to found and build. His professional practice and hospital work interested him and gave him a living. He had parted with his real estate holdings all too easily, impoverishing himself that others might thereby profit. At his death, on the 13th of March, 1873, he was comparatively a poor man, whose last days were embittered by litigation, instigated by others through his first wife, in an attempt to obtain the donation claim Maynard had endeavored to get for his second wife east of his own claim, the result being that neither wife obtained the desired land, the value of which today is several million dollars. Dr. Maynard was a Mason, and his body was the first buried in the cemetery of that order, now known as Lakeview.

Dr. Maynard was a real pioneer. He came in the days of those who, finding only the savage, opened the country to civilization. He came when to do so meant danger, difficulty, privation, suffering, large expense, separation from home and friends, and troubles innumerable and indescribable; and when it also meant excitement, novelty, room, freedom and the opening of a new country to the people of the world, with a place in history for the participants in the stirring events incident to such times. He was active, prominent and unceasing in his efforts necessary to promote the general good, socially, officially, politically, commercially and morally. He was the "First" in more enterprises and undertakings than any of his contemporaries. Without him Seattle might have become as great a city, but with him it had to be.

ORIGINAL CONTRIBUTIONS.

SWEDENBORG'S VORTEX-RINGS AND SOME OF THEIR APPLICATIONS IN THE REALM OF NATURAL SCIENCE, WITH ESPECIAL REFERENCE TO THE SUBJECT OF THOUGHT.

By E. R. Edson, M. D.,

SEATTLE, WASH.

(Continued.)

(2) Vortical Motion in the Inorganic World.

Motion in the form of a simple whirlpool is commonly observed, as evidenced abundantly in such media as water and air, i. e., whirlpools, whirlwinds, tornadoes, and cyclones; but motion in these media may progress one degree further and follow the type shown in Seventh Form, that of the perpetual vortex. Whether perpetually-vortical motion in water alone has ever been demonstrated in any of the great natural whirlpools I do not know, but I have succeeded in producing it artificially. I took an ordinary globular

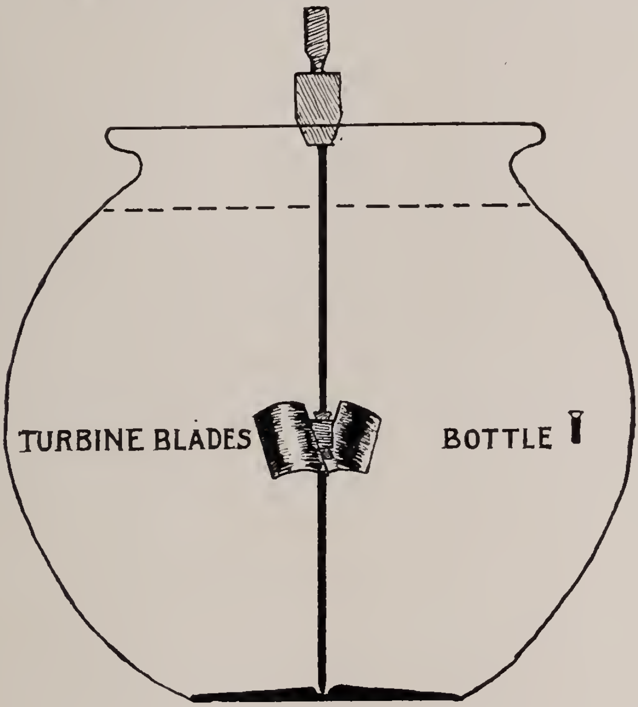

Fig. 2. Glass bowl and apparatus for producing a perpetual whirlpool in water.

fish-bowl, nearly filled it with water, and created a whirlpool at the middle by rotating a pair of small peculiarly shaped turbine blades at the centre of the globe, using an ordinary hand-drill to rotate the shaft. When the current was well established I found that a small object such as a bottle, so weighted that its specific gravity corresponded with that of the water, followed the course of the current in precisely the manner in which I have shown Swedenborg's perpetual vortex or vortex-ring.

If we study water-spouts we find actually the same phenomena in essence. A water-spout is caused by a whirlwind near the surface of some body of water. As the whirl becomes well established the water beneath begins to whirl as well. Next, the rarefaction produced in the core of the vortex causes a similar rarefaction in some of the water below and it rises in the form of aqueous vapor upwards in the whirling column. When the summit of the whirl is reached the air-currents become broader and broader in their movements, the cooled air tends to gravitate, and the aqueous vapor, condensed by the fall of temperature, is often precipitated, producing a heavy rain. Thus we observe the water returning to its original level and state of aggregation, and although its fall from the clouds to the surface of the body of water is more or less vertical, yet it illustrates a more or less imperfect type of the perpetual vortex as seen in water and air combined. If a waterspout continued for a sufficient length of time, it would of necessity cause repeated changes of state of the water affected, i. e., from water to aqueous vapor and from aqueous vapor to water, and would, therefore, produce a perpetual (in type) vertical circulation.

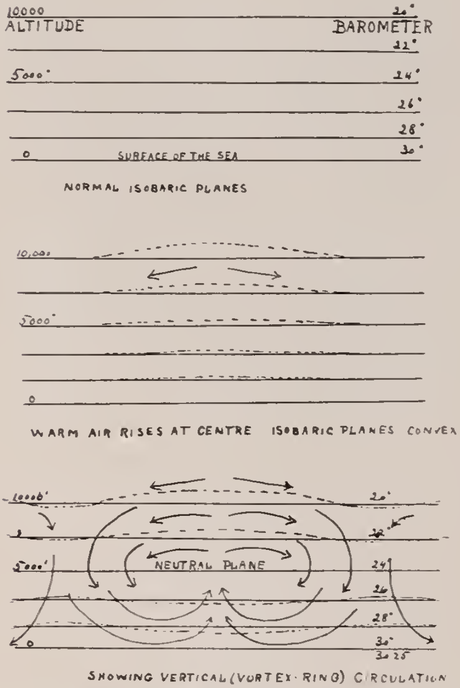

Fig. 3. The Mechanism of a Cyclone. (From Whirlwinds, Cyclones and Tornadoes, by William Morris Davis.)

A better illustration of perpetually vortical motion is found in the cyclone, and I find an excellent description of such a current in William Morris Davis' Essay on Whirlwinds, Cyclones and Tornadoes, an essay which formed the basis of a course of lectures delivered at the Lowell Institute in 1883 and which was subsequently published in *Science.* It should be borne in mind that the sun's radiation is the cause of all these vortical disturbances of our atmosphere, as is clearly stated by Mr. Davis: "It must be, then, the sun's heat, as was supposed, that destroys the normal stable equilibrium of our atmosphere; and to a disturbance of this kind we can refer more or less directly all storms, and, indeed, all winds that blow about the earth. Without the heat that is constantly showered down on us, we should gravitate into a lifeless condition of stable equilibrium, chemical, organic and physical, and there remain in endless death. But the sun allows no such inactivity on his attendant planets; it keeps them alive and at work."

How is it, then, that the Sun causes a cyclone? As Mr. Davis' description would occupy too much space in this essay, I will present his ideas in condensed form. Let us imagine that the atmosphere over the sea is divided into layers by barometric planes at different levels, as shown in the accompanying diagram. Inasmuch as the air is usually heavier below than it is at a higher level, we find these barometric planes farther and farther apart as we proceed upwards. Now as a result of the Sun's radiation, the air nearest to the ocean's surface becomes warmer and lighter; consequently a tendency to rise is produced and an upward current begins at some point just as the warm air rises in a chimney. As soon as this is begun, the air of the lower layer begins to flow in horizontally from every direction towards the center, and since the inwardly moving currents cannot meet exactly at the same point, a central whirl is established, as is shown in the accompanying figure.

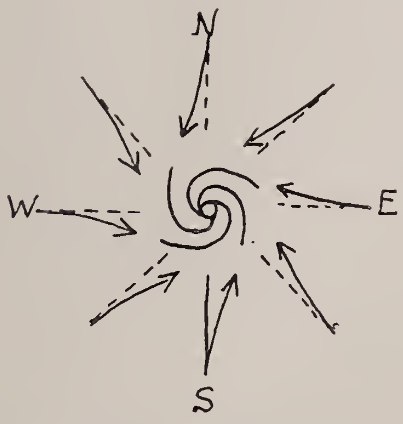

Fig. 4. Illustrates the inward spiral blowing of the storm (from ibid.)

As we have already seen, the only form of motion in which the forces of the three dimensions of space, acting in fluid media, can combine harmoniously, is that of a vortex. Consequently an ascending vortical current of air is formed, the expanded base of which becomes larger and larger as the intensity of the whirling motion is increased. So the air rushes upward; as it does so, it becomes cooler and a part of its contained aqueous vapor is condensed into rain; this condensation produces still more heat, the air is warmed again and rises to a still greater height than it would have risen had it not contained a great amount of energy stored up as the latent heat of water-vapor. The currents then increase the extent of their horizontal gyrations, the air becomes cooler and cooler, until it is relatively heavier than the air at the extreme periphery, when it gradually falls, is sucked in by the inwardly flowing currents at the base and flows upwards through the central vortex again. To more fully illustrate this idea, I will quote directly from Mr. Davis again: "Here we have an excellent illustration of the convectional motion of the wind in a storm. It ascends in the center where it is lightest; it then flows outward down the barometric gradient; it sinks at the marginal region of higher pressure and then flows inward, down the reversed gradient, back to the center again. This may be called the vertical circulation of a storm; and it will be continued as long as the central current is warmed to excess so as to raise its isobaric surfaces. In the desert whirlwind we have seen that the supply of warm air depends immediately upon contact with the surface-sands heated by direct sunshine. In the cyclone at sea, the greatest part of the warmth needed is given out by the vapor that condenses at the center and falls in the heavy rains without which a cyclone cannot form. Such a storm may last many days."[2]

We will pass now to more harmonious forms of perpetually vortical motion such as exists in the ether, the rarest medium of whose phenomena we are cognizant. It is evident, as we progress from matter in a denser to matter in a rarer state of aggregation, that forms of motion more nearly approaching an absolutely harmonious type are possible. Thus we can produce a perpetual vortex in water; we find true perpetual vortices existing in air-currents, especially cyclones; and now, when we progress to ether, the rarest of the three media, we should naturally expect to observe phenomena indicating a greater degree of harmony of movement. It must be borne in mind that ether, in its motions, follows the same general laws which govern those of other states of matter; like water, it flows in currents, that is, its particles actually move through space, just as a stream, impelled by the force of gravity, flows down a hill-side, guided in its path by its restraining banks.

and just as air flows from one point to another, whether horizontally, vertically, or vortically, drawn on by an attractive force. Again, just as we observe waves in water, that is, a transference of motion from one particle to another, and just as we observe similar waves or vibrations occurring in the air, so also must we expect to find, in the ether, wave-motion or transference of vibrations. We are dealing with practically the same thing then as water and air, except that the ether is much rarer; but it has density, it flows in currents and it exhibits wave-motions. We should therefore expect to find similar motions in the ether, but with this difference: that, just as air-currents and air-waves have greater velocity than have water-currents and water-waves, so ether-currents and ether-waves must have greater velocity than have air-currents and air-waves. That such is true may be readily comprehended: thus, in the ocean the greatest velocity acquired by any of its regular streams is not over four miles per hour, while an ocean wave commonly travels past a steamship going at a speed of thirteen knots, in the same direction as the wave. In air, likewise, a similarity is observed: a wind possessing a velocity of 100 miles per hour is extremely violent; while sounds (air-waves) travel at a rate of 743 miles per hour. Now we know that light-waves travel at a rate of 190,000 miles per second, and we should similarly observe that ether-currents, in which there is actual translation of the ether itself, travel at a slower rate.

That ether-currents, translations of ether particles from one point to another, occur, is evident. One can readily cause a puncture through paper by placing one or many sheets across the path of a spark passing between the two poles of a static machine. Similarly, I found on the body of a man who was killed by contact with a street arc-circuit, a wound of entrance and a wound of exit similar, in principle, to bullet wounds; on this man's right palm was a punctured blackened burn, about one-fourth inch in diameter, and on the left palm was a larger circular, punctured, blackened burn, having the appearance of a wound of exit.

The question now arises, what is the form of these currents? Are they linear, spiral or vortical? Ampere long ago demonstrated the rotation of a vertical bar-magnet by an electric current. "In a glass jar filled with mercury he floated a cylindrical steel magnet, maintained vertical by a platinum counterpoise screwed beneath it. The upper end of the magnet was hollowed out like a cup; a little mercury was put into it and into this the point of a vertical conductor dipped in communication with one of the poles of the battery. The other pole was put into connection, by means of a wire, with the mercury in the jar. As soon as the current passed, the magnet turned around its axis. The direction of the movement depends on that of the current and changes with it; it depends also on the nature of the pole that is brought into action. When the current enters by the point of the wire, if the pole that is in action at the top is the north pole, rotation takes place in the contrary direction to the hands of a watch, that is to say, from east to west passing by the north."[3] Faraday demonstrated the fact that the action of a magnet could cause a continuous rotation of a current.

Again, "If a metre or two of a flexible conductor, such as gold thread, be made to carry as strong a current as it will bear, and a vertical bar-magnet be brought near it, the thread will coil itself into a spiral, half of it twisting around the marked end, and the other half twisting as a part of the same spiral around the south end (Lodge). * * * If a current be sent through a stream of mercury falling from one pole to the other of a strong U-magnet with its plane vertical, the liquid will at once twist itself into a flat spiral (Thompson). It would appear, therefore, that precisely as a current is surrounded by a whirl of lines of magnetic force, so a magnet is equally surrounded by an electric current whirl. Ampere's theory, therefore, supposes simply that electric currents circulate around the molecules of a magnetic substance, thereby polarizing them. * * * The act of magnetization, therefore, consists simply in rotating the molecules so that their magnetic axes face in the same direction."[4]

It will be well now to examine some of the phenomena observed in experimenting with a bar-magnet. If we place such a magnet under a horizontal plane of glass, sprinkle iron filings on the glass and then gently tap the glass, the filings will arrange themselves in lines extending from one pole to the other pole of the magnet, as shown in the accompanying figure.

The lines produced by the filings are called lines of force. Now if we place a compass along these lines of force, we find that the direction of the needle coincides and points to a

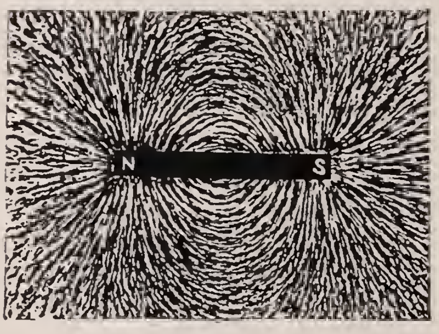

Fig. 5. Lines assumed by iron filings about a bar magnet.
(From Elementary Lessons in Electricity and Magnetism, by Silvanus P. Thompson.)

current going in at one pole, through the magnet, out at the other pole, and then around on the outside to the first pole. One might naturally conclude that these lines represent the actual paths of the ether currents, but they do not. They merely indicate, I believe, paths which particles follow in traveling between points of different potentials, or points of different ether densities.

In order to explain this properly we must revert to the theory of Ampere, who believed that magnetism was simply a vortical electric current, or, in other words, that an ethereal whirlpool existed about a magnet. Whether Ampere went farther than this and stated that these ether-currents existed in the form of Swedenborg's vortex-rings, I do not know, but the phenomena of magnetism may be explained on this principle. To properly illustrate this idea I will revert to the subject of vortex-ring motion in water and air. Suppose that we so weight a very small bottle, of uniform calibre, that its specific gravity is very slightly less than that of water, so that it will barely rise to the surface; then suppose we have one end a very little heavier than the other, so that the bottle will remain vertical in the water. Now, suppose we should place such a bottle in a perpetual whirlpool in the glass globe described earlier in this article, what would it do? It remains with the light end up while moving spirally upwards in the outer ascending whirl; but, if the difference in weight between the two halves of the bottle were little enough, it would descend in the inner whirlpool, *light-end-down,* the downward suction force of the whirlpool overcoming the effect of gravity. This would of necessity occur, just as, if we were dragging a stick by a string tied about its middle, the lighter end would be in advance of the heavier end. In such a case the bottle would *point,* throughout its course, with the vertical direction of the current, point up when the current ascended and point down when the current descended. It is reasonable to believe that a similar pointing would occur in perpetual air-vortices, if their motions were sufficiently violent.

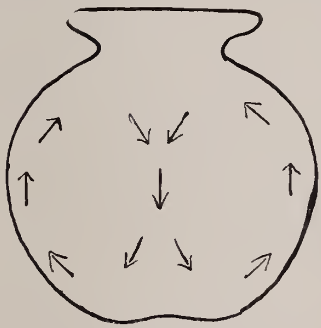

Fig. 6. Illustrates positions of bottle in perpetual whirlpool of water.

If we make a vertical section of a perpetual whirlpool in water, we would find the bottle, if it were circulating in the pool, pointing in this fashion, in various positions.

We observe a striking analogy between this condition and the behavior of a compass when placed along the lines of force in and about a solenoid and likewise about a bar-magnet. This points to the existence of a perpetual whirlpool, a Swedenborg's vortex-ring, in and about the magnet; that the core of the whirlpool is in the magnet, and the outer current in the surrounding field. Such a current would produce a convergent ether-vortex at one pole, and a divergent ether-vortex at the other, i. e., an attractive pole and a repellant pole, a positive and a negative. Under such circumstances, if we placed two convergent or two divergent poles together they would repel; but if we placed a convergent pole near a divergent pole they would attract.

If we believe in such an ethereal circulation about a magnet, what causes this continual vortical circulation? We saw, in studying cyclones, that their cause was a difference in density of the air and also of the aqueous vapor at different levels, and that they exhibited polarity. We must similarly conclude that the cause of perpetual ether-vortices is a difference in ether density at the two poles. It is probable that, just as the Sun is the agent which produces a polar difference in density in air and aqueous vapor, creating a cyclone, so the Sun likewise, by his ether-radiation, is the proximate cause of similar phenomena of the ether.

We may explain the pointing of a compass about a magnet in this way. A compass, from an ethereal point of view, is such a vortex-ring. There is a difference of ether density at the two poles; consequently, one end is ethereally light and the other is ethereally heavy, so that the light or heavy (ethereally) end follows a similar relation in ether density about the magnet. Again, the ether vortices about the two poles of both the compass and the magnet must harmonize in order to attract. In further explaining the lines of force shown by iron filings when placed on a pane of glass

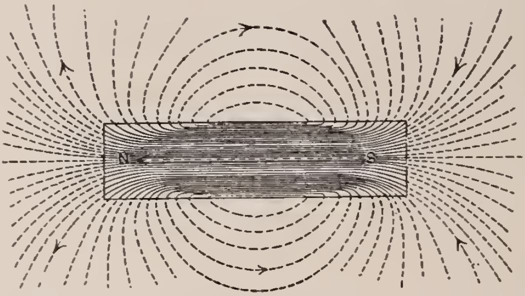

Fig. 7. Diagram of paths of lines of force of a bar magnet. (From Introduction to Physical Science, by A. P. Gage, Ph. D.)

and acted on by a magnet underneath, we must reflect that these iron filings are acted on most powerfully by the suction force of the magnet's ether-vortex, the ether passing between the units of the iron. The filings do not rotate about the long axis of the magnet because the transverse or whirling movement of the ether is much weaker than the upward or downward suction force. That a tendency to such rotary motion exists was proved by Faraday, by his experiment causing a current to rotate about a magnet; also by Ampere, who, by his experiment described above, caused the action of a current to cause rotation of a magnet. In both of these experiments, the suction force could not act perceptibly.

Having given this description of a few of the phenomena of magnetism in the case of small magnets, we would likewise expect to find a similar condition of affairs in and about our own earth. Swedenborg, in 1745, stated that the earth was enveloped by spires or spheres of ether.[5] It is highly probable that the phenomena of the earth's magnetism are due to perpetually-vortical ethereal currents, after the form of Swedenborg's ring. We may progress even farther than this and state, with reasonable certainty, that, as the original nebulous mass of our own solar system began to contract, it developed a vortex-ring motion of the same type, and also that such ethereal currents exist, in a very active state, in and about the Sun today. I say that such a form of motion existed for this reason; forces acting harmoniously in the three dimensions of space produce vortical motion; consequently, if a nebulous mass contracts, a vortex will be formed, which, in process of time, must become perpetual in type—a vortex-ring.

(*To be concluded.*)

FREE DISPENSARIES AND THEIR ABUSE.*

By Mrs. Edith P. de Veaux.

SEATTLE, WASH.

During the seventeenth and eighteenth centuries, in America, there were erected, in connection with all commercial cities, almshouses or pest-houses for the care of sick immigrants and sailors. This was done to guard the community against infectious diseases. In the City of Brotherly Love, it soon occurred to Benjamin Franklin and others, that some provision ought to be made for the proper care of the sick among their own people, and accordingly, in 1751, the Pennsylvania Hospital, the first in America, was established.

In connection with the hospital, an out-patient department was established the following year in order, as was stated, "to relieve the sick poor without causing them the pain and inconvenience of being separated from their families: to afford relief without publicity according to the refined precepts of Christianity"; and to lessen the expense. This service to the poor in their homes was furnished by so-called "apprentices," and became so extensive as to demand the use of a horse. Previous to 1797, no record was kept of patients visited, but in the twenty-one years following, we are told that more than 15,000 persons had received treatment as out-patients. Owing to the organization of two independent dispensaries, in 1818, this out-patient department was discontinued.

The second hospital to be erected in the United States was the New York Hospital, in New York City, which was founded in 1770, but owing to the war, was not formally opened until 1791. At about the same time the New York Dispensary was established, under the auspices of the New York City Medical Society. In 1820 the first special dispensary, that of the New York Eye and Ear Infirmary, was opened, and since that time all kinds of free dispensaries have multiplied, far beyond public need.

The dispensary has had its greatest development in New York, a development which is due very largely to the fact that part of its support is derived from an annual municipal subsidy. Other causes are the demand by the medical schools for free clinical material, and the attempt of the wealthy churches to find an outlet for their charitable impulses which shall, at the same time, increase their temporal power. The "Diamond Dispensary," so-called, was founded by a millionaire for the sole purpose of furnishing material for the clinic of one of the leading medical schools.

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*Read before the Woman's Century Club, Seattle, Wash., February 12, 1904.

Dependent alone upon charity for support, New York City could not have maintained so many dispensaries. In 1900 there were sixty-three in Manhattan alone, serving not only the poor, but the pauperized rich, gratuitously. With the multiplication of these medical charities, the effect upon the medical profession began to make itself felt, and investigation into the causes led to the discovery of a gigantic abuse, about which so much was written in 1897. Dr. Stephen Smith, in a report to the State Board of Charity, is authority for the statement that from 1791 to 1870, applicants for medical charity bore a ratio to the total population of only 1.5 per cent. against the ratio in 1897, of 49.7 per cent., representing nearly half the population as medical paupers. Of course something was wrong.

It was found that the well-to-do, even millionaires, were using the dispensaries; in some places were crowding the poverty-stricken from the door. They came in carriages, clothed in fine raiment, decked with jewelry. The "Diamond Dispensary" took its name because of the large predomination of this class. Clinic material was what they wished; no question of ethics concerned them. There was also the millionaire in poor clothes, the lawyer, the broker, the journalist, with incomes varying from tens of thousands per year to twenty-five dollars per week. It has been estimated that fully fifty per cent. of charity patients are persons whose financial position puts them wholly beyond the scope of charity, and that not more than twenty-five per cent. represent the extreme of poverty. This means that fully fifty per cent. of the funds provided by charity for the poor, to whom it rightfully belongs, is diverted by the rich. One writer classes these wealthy paupers as criminals guilty of obtaining under false pretenses that which does not belong to them. They cheat both ways, the poor to whom belongs treatment, and the physician who is worthy of his hire. One physician gave up his dispensary work because his regular patients began to visit the dispensary and his private practice was becoming ruined. It is the outgrowth of a desire to save money, regardless of the shock to self-respect and of the rights of others. Ever since the world began, we are told that man has been seeking to obtain something for nothing, a corrupting desire, pauperizing and degrading in its effects. The first thing a man or woman will accept as charity is medical attendance. The first step toward pauperism taken, the second is easy. "A man begins by taking what he should not receive, begs what he does not deserve, demands as a right that to which he is not entitled, not only free medical service, but free food, free lodging, free clothing and fuel." Dr. Geo. F. Shrady[2] says, in his article on, The Dispensary, A Propagator of Pauperism: "A man who would scorn to take other things without pay, lies to the doctor for free advice. Thus we see that the dispensary gives the first lesson in indigence and degradation."

It is said that, "the abuse of charity has worked more mischief and brought more misery in its wake than have pestilence and famine." The first stimulus to labor is hunger. What need to work when the necessaries of life may be had for the asking? Why be careful to observe the laws of health when advice and medicines are free? The beneficiary of charity will grow shiftless and lazy. Thoughtless charity has made the tramp, and nurtures the discontent of the anarchist. It makes possible the professional beggars, against whom we are warned from time to time by organized charity associations. Indiscriminate medical charity must bear the responsibility of a large part of the degradation and dissatisfaction of mankind.

In view of the harm the free dispensary evidently has done, we may ask, has it not done more harm than good? Our answers will depend largely upon our point of view. The influences of good and harm are so far-reaching in their effects, we cannot reduce them to mathematical quantities for calculation and comparison, but two other questions may help us to form an opinion. Is it not probable that all the free medical relief necessary for the poor, even in a great city like New York, would be furnished privately, if there were *no* free dispensaries? Granted that it would not, that some loss of life or limb would follow entire dependence upon private medical charity, privately administered, is the loss and suffering sufficient to demand the free dispensary and its attendant moral degradation? Which has the greater value, the soul or the body, the moral or the physical nature? I do not presume to say what the medical colleges would do for clinic material, but their number would doubtless be limited and, with all due respect for the profession, I should say it would be a good thing. The conservative estimate that about half of them might be closed without detriment to anybody. But the forces which brought so many into existence will serve to continue the greater number of them. Some effort has been made to check the abuses, by means of legislation, but it has not been so effective as it should be or could be, if the physicians and the management of the dispensaries were united in their honest convictions and had the courage to back them.

In the Rhode Island Hospital dispensary, a system for checking abuses was inaugurated (1896), under which, during the first six months, thirty per cent. of the applicants for free treatment were rejected, and since that time the yearly average has been twelve per cent. The system provided for a conspicuous placard opposite the entrance, stating that the department was only open to the poor and that no others would be treated; those wishing treatment must bring letters of recommendation from well-known reputable persons or societies. If no such letter is forthcoming, the applicant must sign a statement to the effect that he is unable to pay, and submit to a rigid examination. The moral effect of the examination is good.[3]

The first law regulating dispensaries passed by the New York Legislature in 1897 was vetoed. The present law was passed in 1899, and seeks to regulate the establishment and operation of dispensaries by placing them under the supervision of the State Board of Charities. The statute furnishes a legal definition of what constitutes a dispensary, and the mode of procedure under which licenses may be granted; it directs the formulation of rules and regulations by the State Board of Charities in accordance with which dispensaries shall furnish and applicants receive medical and surgical relief, and medicine. It provides for visitation and inspection by the board, the revocation of licenses for cause, and penalties for failure to observe the rules and regulations, and provides for the punishment for misdemeanor of persons who obtain treatment on false representations.[4] The State Board of Charities made their rules and regulations, which they "deemed sufficiently radical," in their effort to "proceed cautiously" in placing "unduly severe restrictions" upon the dispensaries in operation.

The Committee on Dispensaries, in a report to the State Board, 1902, states that the most important of the nine dispensary rules have not been strictly observed. One is that applicants are required to sign cards stating that they are unable to pay for treatment, and the registrar is required to make investigation, keeping the results and card among the permanent records of the dispensary. In a majority of instances investigation consists of simply questioning the patient. Another regulation, not fully observed, requires a certificate each year, signed by the manager of the dispensary, to the effect that all the regulations and orders of the Board have been complied with.

It is small wonder then, that license does not restrict and legislation does not regulate. The law has been in operation four years. In New York City, during that time, two dispensaries have been permanently discontinued, while five new ones have been licensed. There has been an increase in dispensary attendance of eight-tenths of one per cent. in Manhattan borough, which, though not in proportion to the increase in population, and showing a tendency to check existing evils, is a vastly higher percentage than it should be, when one considers the ratio of dispensary applicants to the whole population as given by Dr. Smith in 1897. In the smaller cities of the state there has been a much greater decrease in dispensary attendance. The number of persons treated in Greater New York in 1902 was 889,157, while in the rest of the state it was 27,000. One can readily understand that thorough investigation in New York City involves much more difficulty than in smaller towns, but it is not impossible. Once let it be thoroughly understood that a rigid inquiry follows upon application for free medical treatment and there will be a decided falling off in the number of applicants. About ninety per cent. of the dispensaries are now receiving small fees of from ten to twenty-five cents from each applicant, but the policy is not good. It cheapens the value of professional medical attendance; it prevents the institution from refusing the benefits of the dispensary to persons who are able to employ and pay for the service of a private physician, and such charges seem to ease the public conscience and make a man think he is paying his way and has a right to what he receives.

About a year ago a free dispensary was started in this city, but I have learned that the medical fraternity frowned it down. There is no need for one here, and it is much easier to prevent the establishment of a dispensary than to regulate one after it has once started. Let all who are interested in the welfare of the city join in the efforts of the physicians to keep out the pauperizing dispensary.

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EXTRA-UTERINE PREGNANCY.*

By Frank W. Hall, M. D.

VICTORIA, B. C.

When an impregnated ovum becomes fixed and begins to develop outside of the uterine cavity ectopic gestation, or extra-uterine pregnancy, is established, the varieties being tubal, ovarian and abdominal.

Etiology. The point at which the spermatozoa meet and impregnate the ovum is not known. The ease with which the spermatozoa pass from the vagina through a virgin os uteri into the uterus, and the occasional cases in which they travel through an almost imperforate hymen, make it reasonable to suppose that they may pass as readily up the uterus into the fallopian tube, and even into the abdominal cavity. Pathologic or abnormal conditions of the tube, however, form the most important factor in the causation of ectopic gestation. Chief among these conditions are congenital deviations from the normal type, such as exaggerated convulsions, diverticula, sagging and attachments by adhesions, resulting in the distortion of the tube, pressure from adjoining organs, thickening of tubal walls, either congenital or acquired, desquamative salpingitis, growths either in the canal or the walls, etc.

Pathology. With the establishment of pregnancy in the tube the uterus begins to enlarge, and up to the fifth month is usually about one-third smaller than intra-uterine pregnancy of the same age. Rupture of a tubal pregnancy, with death of the ovum, checks uterine growth and involution follows. If the ovum does not die, the uterus may continue to enlarge, but to a lesser degree.

The Decidua. The formation of the decidua is one of the most notable *changes* in the uterus in ectopic gestation. It resembles the decidua vera of normal pregnancy, and is thrown off in one complete cast about the time of primary tubal rupture, and this event is generally accompanied by metrorrhagia. The membrane is cast off, even if the ovum remains alive. The decidua is one-eighth to one-quarter inch in thickness, rough on its uterine, and smooth on its inner surface, and shows no trace of decidua reflexa, nor of decidua serotina.

Diagnosis. The principal features upon which a diagnosis rests are: Arrested menstruation, generally but two or three days over time. A sudden attack of pain, of a cramp-like character in the lower abdomen, located more especially to the affected side, associated at times with an intense pain in the rectum of a lancinating character. The blood passed is usually dark, grumous in appearance, and its flow is generally more or less constant. The paroxysms of pain continue for from half to two hours, and are at intervals of from one to four days or more. Bimanual examination is painful, especially when you palpate the tumor on either side of the uterus. The uterus is changed in size and consistency, and is dislocated according to position and size of the blood-tumor. If the patient has not nursed a baby for more than a year, or has not previously been pregnant, the presence of cholostrum is an important symptom, especially when taken together with other symptoms.

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*Read before the British Columbia Medical Association, October 30 and 31, 1903.

Rupture is diagnosed by the suddenness of the attack and the excrutiating pain followed by more or less syncope, and if it is possible to obtain a history from a relative, the data already given may aid in corroborating the suspected diagnosis.

The *differential diagnosis* is at times most difficult, and in some cases impossible without an exploratory incision.

First. The condition most likely to mislead would be the rupture of a large ovarian hematoma, especially if there is a continuous oozing from the torn surface.

Second. Subacute gonorrheal pyosalpinx.

The symptoms resemble those of tubal rupture in every particular, so that one may be easily lead into making a wrong diagnosis, but will generally find the suppurative change effecting both tubes simultaneously, while tubal pregnancy is seldom present in both tubes. A small vaginal incision into Douglas sac would soon clear the diagnosis, but as either condition requires surgical treatment to bring about a well-being of the patient, I do not see as it matters much.

Treatment. We should look at the intra-uterine pregnancy as one would regard a beginning malignant neoplasm, which should be removed as soon as a diagnosis has been made.

I have dismissed the treatment of (1) Aspiration of liquor amnii; (2) Injection of morphia into the tubal sac; (3) Treatment by means of electricity, as being not proven, although there is evidence of these means being successful.

I recognize but two methods, the conservative and surgical treatment.

The conservative consists briefly of keeping your patient absolutely at rest, with a nurse constantly in attendance; an ice-coil applied to the abdomen; morphia to keep her comfortable and a liquid diet.

The surgical. The abdominal incision should be rapidly made and be of sufficient length to permit one to work as rapidly as possible. The blood ofttimes wells up out of the abdomen as from a fountain. No attention should be paid to this. The pelvis must be reached at once, and the affected tube or tubes be brought up at once and tied. Then proceed to have warm saline solution poured into the abdomen by an assistant, while the operator removes all clots of blood from the pelvis and lower abdomen. The abdominal cavity is then left filled with saline solution and the abdomen closed in layers.

I have had thirteen cases of tubal extra-uterine pregnancy, one of which died before operation and a post mortem revealed pregnancy in a tube of about six weeks duration, the rupture having taken place close up to the left cornu of the uterus.

Two I diagnosed before rupture, and ten some hours after rupture: Eleven recovered and one died eighteen hours after operation, of shock from loss of blood and operation. In all cases after rupture I have an assistant, at the time I am preparing my patient, to transform 30 to 40 ounces of saline solution into the cephalic or median basilic veins. I always leave the abdominal cavity filled with hot saline solution and have saline injected into the bowels every two hours for the first twenty-four or forty-eight hours, also a hyperdermic of strychnin, gr. 1-30, every four hours, for the first three or four days and open the bowel on the third day.

CLINICAL REPORTS.

TWO CASES OF DOUBLE SYNCHRONOUS AMPUTATION.

By MONTGOMERY RUSSELL, M. D.,
SEATTLE, WASH.

The first case here given is an example of a slow train injury and the other of a train in rapid motion. In accidents caused by slow trains, as in switching and coupling, the force of velocity is much less, and these wounds are different in certain ways from those received by fast trains, and are more nearly similar to wounds received from other machinery and heavy bodies. In bumper accidents, or in the case of a leg or arm being run over by a train or car at slow speed, it will be found that the parts have been squeezed or pulpified, leaving a margin marked by the edge of the bodies between which the member has been caught, and it will be discovered by dissection that the tissues adjacent to the lesion are practically normal. The damage seen is generally the full damage done, and can be so considered in treating the same.

In the case of a fast train passing over a limb, a different state of affairs is often presented. The lesion may in some instances be apparently just as sharply defined, but the fact is that destruction has been accomplished way beyond this margin, and what appears to be uninjured tissue is in reality destroyed, or so devitalized that it will die, by reason of the shock to which it has been subjected through the impact to the part of such a powerful force. This condition exists for varying distances from the line of apparent injury, according to

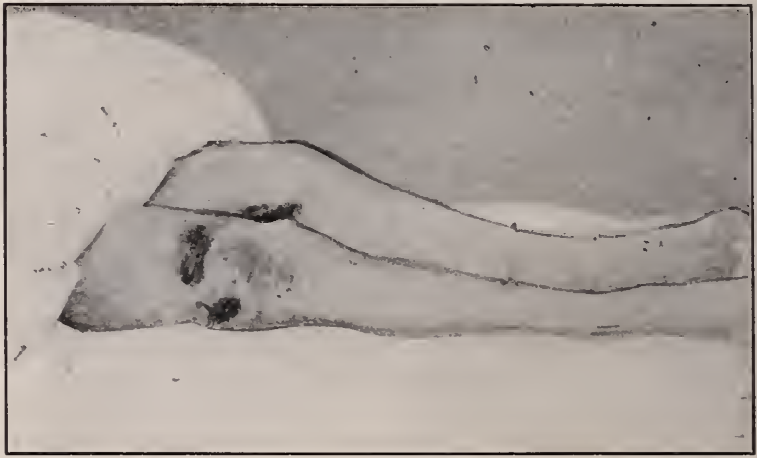

FIG. 1. Legs run over by car wheels of slow train, showing no break in the skin. The dark spots are ecchymoses.
(Herrick's Military Surgery.)

the speed and weight of the train. The actual cause of death of these tissues, beyond the line of the wound, is the plugging for varying distances, of the large artery of the part by a coagulum of blood. This often causes gangrene rapidly to supervene, necessitating amputation of limb higher up. The speed of the train must therefore be considered in cases of this kind, in order to arrive at a definite conclusion as to how severe it may be and as a guide as to how it should be treated.

Case 1—A. L., age 22 years, unmarried, brakeman on freight. While switching car on C. & P. S. R. R. at C. & S. brewery, between five and six o'clock a. m., slipped and fell under car next to engine, the wheels passing over both thighs, mangling and crushing them to pulp. He was brought to the city on a Northern Pacific switch engine and removed at once in the ambulance to Providence hospital, where I amputated both legs, as soon as he had recovered somewhat from the shock. I amputated the left thigh about three inches from the hip joint, and the right at junction of upper and middle thirds. He nearly died on the table during the operation, but revived after injection of stimulants and transfusion of normal salt solution in the median basilic vein of the arm. He never recovered entirely from the shock, and was conscious for only a few minutes before his death which occurred at 2:30 o'clock p. m.

With the exception of considerable ecchymosis of the skin over the thighs, the appearance did not indicate the amount of damage to the bones and soft parts, which were comminuted and pulpified. The condition of the injury is illustrated in the accompanying Fig. 1.

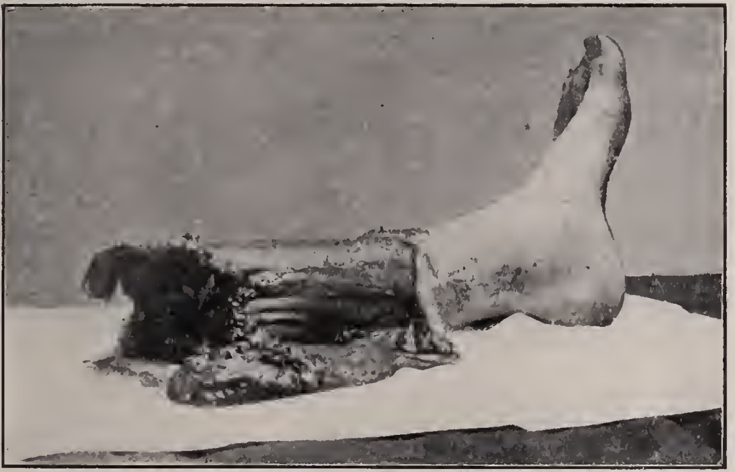

FIG. 2. Distal portion of leg which was completely crushed off by a fast train. (Herrick's Military Surgery.)

Case 2.—E. N., age 18 years, unmarried, switchman on C. & P. S. R. R. While standing on railroad track watching a car that was being switched, was run over by fast train, the car wheels passing over left leg, completely severing it at about the middle third, also crushing and mangling the right foot. The accident happened so quickly that he did not know his left leg had been cut off until he saw it lying on the track beside him. He was immediately taken to the hospital, suffering considerably from shock, but soon responded to the usual remedies. I amputated the right foot at the tarso-metatarsal articulation and it did nicely, giving him a good, useful stump. The left leg was cold and clammy to the knee, and the bone shattered considerably above the apparent point of injury, and in order to get into sound tissue, I amputated at junction of middle and lower thirds of the thigh. The amputation of this leg above the knee proved to be a wise provision, saving another amputation later on, as the popliteal artery was found filled with a long plug of coagulated blood, completely shutting off the circulation below the obstruction.

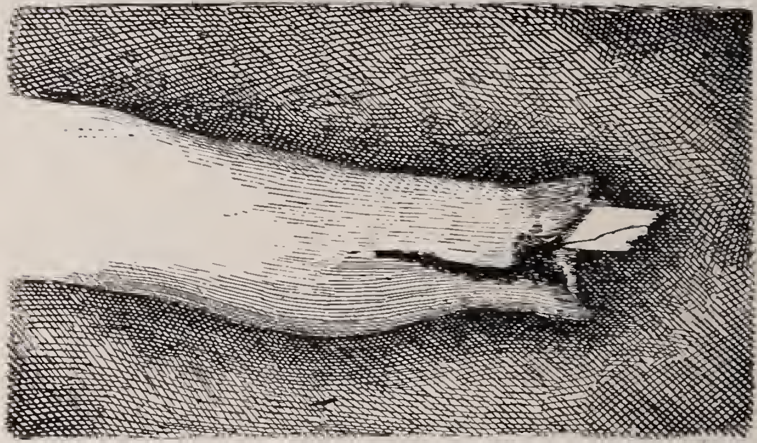

FIG. 3. Appearance of proximal portion of leg completely crushed off. (Herrick's Military Surgery.)

This young fellow made an uninterrupted recovery and gets around fairly well, with an artificial leg and a brace in shoe of right foot. The conditions of this form of injury are shown in Figs. 2 and 3.

NORTHWEST MEDICINE

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JAMES B. EAGLESON, M. D. Managing Editor.

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THE STATE ASSOCIATION MEETING.

The fifteenth annual session will be held in Seattle, July 12, 13, 14.

Members who expect to present papers are requested, at as early a date as possible, to notify the

COMMITTEE OF ARRANGEMENTS

C. A. Smith, C. W. Sharples, G. S. Peterkin, I. A. Parry, G. W. Hawley.

THE MEMBERSHIP OF THE STATE ASSOCIATION.

We wish to call the attention of the profession of Washington to the existing membership in the State Association. The last list of members of the old Washington State Medical Society was published in 1902 and gave a membership of 390. The secretary of the Association gives the present number as 270. It is known that many names of members were carried on the old record who were several years in arrears for dues and should not properly have been included. According to the new constitution the list of members is made up each year, by the secretary, from the names in good standing reported by the component county societies. Since this report must be accompanied by the fee of two dollars for each member, it assures a continuous membership in good standing in the association.

Even with this explanation, however, a deplorably small proportion of the profession has membership in the Association. The Medical Directory of 1902, the last published, numbered the physicians of the state at 640. At present they undoubtedly reach 800. If a state organization of the profession has any value it should contain at least fifty per cent. of the practitioners. This means the present year should result in practically doubling the membership of the past year.

In all lines of activity there is considered an advantage in combinations of allied interests. Hence the multiplicity of trusts, unions and fraternities. If the medical profession, as a body, is to attain influence and strength, it must adopt similar methods of organization. The accomplishment of such ends rests entirely with the individual county societies. If they are dead or asleep it is time to awaken and do something. According to the by-laws, the annual reports from the county societies must be presented to the state secretary not later than the first of May. If a canvass to gather in the available material has not yet been made, we commend the immediate consideration of such work to all the component societies. Let us attend the meeting in July with the assurance that a strong and influential body of medical men and women is yearly increasing in the great State of Washington.

THE PRESENT STATUS OF THE DRUG STORE IN ITS RELATION TO THE MEDICAL PROFESSION.

The *Journal of The American Medical Association*, of March 19, 1904, calls the attention of the medical profession to a growing evil, and a monstrous imposition upon our profession, and one which it is easily within our power to abolish, instead of unwittingly aiding and abetting it as we are now doing. The able editorial above referred to should be read by each member of the medical societies in this country.

The medical profession the world over, by a studied indifference to the commercial side of its existence, has placed a large number of very embarrassing obstacles in its road to prosperity and success. In our rantings against commercialism, which are usually devoid of common sense, we have nearly lost sight of the true meaning of the word. We have so far forgotten the simple commonsense principles of every-day business affairs, which make it possible to live at all, that every manner and kind of lodges, associations or unions can make tools of many of us at any time they wish for any sum they wish to pay.

By our lack of interest or neglect of practical things we have fostered the drug store evil as it exists today. Nine out of ten of the drug stores today constitute the worst form of competition we have, and what is worse and more important, they are a menace to public health and morals. Instead of being our natural allies in relieving human suffering, they are causing more miseries than they are curing, and for which we, as a profession, often receive censure because of the use and misuse of the word drug.

What is the principal thing in the average drug store aside from the obnoxious placards and advertising matter displayed? The omnipresent soda fountain and the tables and chairs where poor deluded mortals can sit and consume some form of concoction which so often makes them buy the still more vile bottled concoctions from the patent medicine counter; and many of these people are our patients, whom we have permitted or advised to go to this same drug store with a prescription. All this with the snap-shot diagnosing and prescribing by the proprietor or his clerk, with the indiscriminate refilling of prescriptions without orders, go to make up a picture of evil and injustice the half of which defies the telling.

We have it within our power to stop it or else to place the same brand upon the druggist who will not comply with the simple requirements of a pharmacy such as we require, that we have placed upon the quack.

MEDICAL NOTES.

Annual Banquet of the Pierce County Medical Society.—The pleasant custom of an annual banquet was inaugurated by the Pierce County Society at the Tacoma hotel, on the evening of March 1, when forty members and guests gathered about the tables and enjoyed a choice menu. The visitors were Drs. Sharples, Heg and Smith of Seattle; Mead of Everett, and Kinnicutt of Chehalis.

Dr. Quevli, President of the Society, acted as toastmaster and appeared in his happiest vein. His store of Irish anecdotes, with an occasional Irish song, would have justified a belief in his origin from the "ould sod." Under his skillful direction something of interest was evoked from nearly all present, covering a variety of subjects of a more or less medical nature. Anecdotes, personal experiences and reminiscences of an entertaining character were greatly enjoyed by all, special reference being due to a poem on the South African war, recited by Dr. Allan, whom the toastmaster presented as the histrionic member of the Society.

The banquet was pronounced a success by all, especially from a social standpoint, the benefit being recognized of this getting close to ones professional brethren at least once a year.

Annual Banquet of the Snohomish County Medical Society.—The Society held its annual banquet at Everett on the evening of February

2, 1904, at the Davenport Restaurant. Drs. Peterkin and Burns, of Seattle, were guests of the evening.

That viands and good cheer abounded was evinced by the lateness of the hour when the banquet broke up and by the fact that the doctors agreed, especially in Everett. Remorse they had none, except that the wee small hours would not permit them to remain later to hear more toasts and jests than were furnished by the following premeditated, but nevertheless excellent program of toasts:

Visitors	Dr. Manning
Fraternalism	Dr. Buchanan
Medical Societies	Dr. Burns
Osteopath vs. Regular Practitioner	Dr. Durand
The Ladies	Dr. Peterkin

Licentiates of the Washington Examining Board.—The following were successful in passing the recent examination, in January, and are legal practitioners in the State of Washington:

H. A. Allgores, G. A. Barrows, O. E. Beet, F. Bentley, E. A. Bingham, J. F. Boyle, H. D. Brown, J. Bryn, W. G. Cassels, W. W. Cheney, F. M. Clussman, F. M. Crosby, F. E. Dent, M. A. Dourur, C. R. Elliott, J. Farrell, M. H. Foster, B. Frost, H. M. Fryer, F. R. Fursey, L. Ganson, A. R. Gould, J. D. Guthrie, G. M. Hawkins, S. B. Hopkins, F. L. Horsfall, R. L. Kerns, A. T. Knapp, J. F. Leslie, G. B. Maxwell, C. E. McClure, E. I. Miller, J. L. Millet, J. W. Moore, C. R. Mowery, C. A. Morgan, D. H. Palmer, F. L. Raberge, D. W. Rawlins, M. C. Robins, F. M. Rossiter, J. D. Shiveley, M. D. Skinner, E. W. Stimson, M. G. Sturgis, G. N. Suttner, J. J. A. Tanner, R. M. Tooken, J. W. Thomas, M. D. Vail, P. D. Vomphul, R. Watkins, E. S. West.

The Annual Meeting of the Idaho State Medical Association.—The meeting for 1904 will be held in Lewiston, on Thursday and Friday, October 6 and 7.

The Annual Meeting of the Montana State Medical Association.—The Montana Association will held its annual meeting in Butte, on May 18 and 19.

Quarterly Meeting of the Whitman County Medical Society.—This meeting will be held at Colfax, April 18. The program will consist of papers on Diphtheria. Symptoms and Diagnosis by Charles James; discussion led by G. B. Wilson; Treatment, by Wilson Johnston; discussion led by R. J. Skaife. R. L. Thompson, of Spokane, will also read a paper.

Death of Dr. A. B. Kibbe.—The death of Dr. Alfred B. Kibbe occurred in Seattle, March 25. His loss is felt by a host of friends and admirers throughout the State of Washington and the Northwest. An extended notice of him will appear in our next issue.

CORRESPONDENCE.

THE COFFEY NEEDLE HOLDER.

PORTLAND, ORE., April 1, 1904.

To the Editor: I have been informed that a number of traveling men selling surgical instruments have been offering a needle holder which I described about a year ago, and that some very cheap instruments are being sold. For my own protection, as well as the protection of the physicians who buy, I wish to state that, while a number of instrument houses have sent for a sample holder and needles, none of the cheaper houses have succeeded in making a creditable instrument. In fact, Tieman & Co., 107 Park Row, N. Y. City, are the only manufacturers who have succeeded in making a perfect holder so far, but I see no reason why any good instrument house could not make a reliable instrument, as the only important point is in properly shaping and hardening the holding plate of the jaws and properly riveting them. Tieman's instruments are quite expensive, and Woodard & Clarke, who keep them in Portland, say they cannot afford to sell the instrument made by Tieman for less than $6.50. As their instrument is absolutely perfect, however, I believe it would not be advisable to take chances on buying a cheaper make until other good houses begin to manufacture it satisfactorily. R. C. COFFEY, M. D.

TO OUR READERS AND CONTRIBUTORS.

Hereafter this journal will be issued on the 10th of each month. All material for publication must be received by the first day of the month. Articles will be illustrated by half tones or etchings when accompanied by photographs or drawings for the same. Reprints of contributed articles can be obtained at the cost of publication, from the Metropolitan Press, publishers of the journal. A limited number of additional copies of the journal will be supplied to contributors.

REPORTS OF SOCIETY MEETINGS.

KING COUNTY MEDICAL SOCIETY.

President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

The first regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce, on the evening of March 7, 1904, President Heg being in the chair. Thirty-five members and visitors were present.

The President announced the following Membership Committee, in accordance with the motion of the last meeting: J. C. Moore, F. B. Whiting, R. M. Stith, J. P. Sweeney and A. W. Hawley.

A report was presented from the Committee on Laboratory, of the work of the past month. The Secretary was instructed to send a notice to the secretaries of all the county societies, calling attention to the laboratory and its facilities for work.

PAPERS AND DISCUSSIONS.

Nephrotoxins. Dr. F. H. Coe presented an account of the investigations, conducted by Dr. Flexner, of Philadelphia, in the subject of the nephrotoxins and their relations to diseases of the kidneys, stating that these investigations indicate the probability of a revision of many of our ideas concerning this class of diseases.

Dr. Winslow stated he had recently seen a child with nephritis, born from a woman suffering with eclampsia. In reviewing the literature, he had been surprised to find twenty such cases reported.

Dr. Read thought investigations of the character reported are of the utmost importance. It would seem that we are about to obtain means of treatment in these cases that will afford great aid to medical efforts. Undoubtedly surgery will accomplish much for them, but in very many instances we cannot get consent for operation.

Dr. Stillson expressed his gratitude to the essayist for presenting this important subject. He thought that, for some reason, nephritis is especially common in this section. As an oculist he often recognized cases before the ordinary symptoms disclosed them to the general practitioner. He described the retinal changes often seen, by which the case is disclosed in an early stage. He had slight confidence in the Edebohl operation for cases presenting ocular changes. He mentioned fifteen cases recently reported in a leading journal, of whom all died, within a year, most of them within six months, though they all showed remarkable improvement for the time being. Such result must be due to liberation into the system of some toxin or antitoxin.

Dr. G. W. Hawley said the pathologists have of late paid much attention to the histology of repair, until recently a much neglected subject. They find indications of newly formed cells that replace those of disease. This must be considered in recovery from kidney disease. The matter of diagnosis has been considerably revised. Formerly the presence of albumin and casts was considered proof of Bright's disease. Now we know a case of nephritis may present only one, or both may be absent and the patient progress to death. Furthermore, the kind of albumin must be recognized, whether serum-albumin, nucleo-albumin or albumoses. The first alone is proof of nephritis, the nucleo-albumin indicating disturbance in the lower urinary tract. On the other hand, a patient may continue to exhibit albumin and casts for a long time without signs of impaired health. We must consider the general condition, as well, in making a diagnosis of Bright's disease.

Dr. Read emphasized the importance of determining the total solids secreted in order to judge of the patient's condition. He cited a case that secretes less than 8 grams of urea daily, from a total of 700 cc. of urine, without albumin or casts. The patient is in an advanced state of nephritis and steadily growing worse.

Dr. Coe, in closing, called attention to the use of cryoscopy to determine the sufficiency of the kidney secretion, and described its application. He also mentioned investigations conducted by different workers, relative to the ingestion of sodium chlorid. Albumin in the urine and edema have been produced by taking large quantities and they have been removed by abstaining altogether from salt.

A Sketch of the Life of Dr. D. S. Maynard. Dr. Eagleson read this very interesting sketch of Seattle's first physician, prepared by Mr. Thos. W. Prosch. The society voted to extend to Mr. Prosch a vote of thanks for the same.

The second regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce on the evening of March 21, 1904, President Heg being in the chair. Sixty members and visitors were present.

PAPERS AND DISCUSSIONS.

Nursing in the Spanish-American and Russo-Japanese Wars.—Dr. Anita N. McGee, of Washington, D. C., addressed the society on this subject. She gave a sketch of the origin of trained nurses in this country and the early training schools. She referred to the international Red Cross Association, explaining its relations to belligerents, and then mentioned the various local Red Cross societies that have no relation to the former. She stated such an organization existed in Japan, with a membership of 800,000, which had been popularized by the nobility. She explained that she and her nurses were going to Japan partly under the auspices of this organization, assisted by the Red Cross society of Philadelphia. She could not say where they would be assigned to work nor whether they would nurse the Japanese or the Russian prisoners.

As an evidence of the value of trained nurses in modern warfare, she gave an interesting description of her experiences during the Spanish-American war. Early in the war she and other interested ladies undertook to provide a few nurses. When typhoid appeared in the Southern camps the totally inadequate provisions for care of the sick became evident. A great demand appeared at once for trained nurses and, while at first a few were sent to selected points, the demand soon called for them by the hundreds. Although members of religious orders were also employed and immune nurses were sent to

Cuba, neither class of women could compare with hospital trained nurses for efficiency and reliability. Her testimony was to the effect that the trained nurse is a necessity in war for the proper care of wounded soldiers.

Dr. Heg expressed to Dr. McGee the appreciation and thanks of the society for her interesting and instructive address. He also took occasion to confirm the doctor's statements concerning the efficiency of the trained nurse in our recent war. He described the confusion and helpless condition of affairs at the Fort Meyer Hospital, at Washington, prior to the advent of the trained nurses, when the sick were cared for by ignorant fellow soldiers. A revolution occurred in this respect with trained nurses. He stated that the credit for this great improvement was due almost wholly to the efforts of Dr. McGee.

Diphtheria: Symptomatology by C. B. Ford; Treatment and Prophylaxis by G. B. McCulloch.—Dr. Ford gave clear account of the course and symptomatology of the disease. He called especial attention to obscure nasal and laryngeal cases, without exudate in the throat, where the diagnosis is often not made till the case is in a desperate or hopeless condition. He emphasised the necessity of keeping these in mind and recounted illustrative cases from his practice where the diagnosis was made from cultures taken from nose or larynx, in the absence of ordinary symptoms.

Dr. McCulloch presented a lucid and succinct description of treatment. After mentioning the ordinary local and general methods he emphasised the necessity of large doses of antitoxin, the only sure and certain procedure. He gives 10,000 units to a child and repeats if necessary. He claimed the remedy is harmless and must be given early. He stated he had never had a death. In addition he said fresh air is the main reliance which must be admitted freely to the patient. As prophylactic, he recommended immunizing doses of antitoxin.

Dr. Moore called attention to the pressing need of a contagious hospital, describing the deplorable condition of many cases of different contagious diseases, who are refused admission to all hospitals and often have no means of treatment. He enquired whether Dr. McCulloch gave antitoxin before the diagnosis is confirmed and was answered that he used it in all suspicious cases.

Dr. Carroll agreed with the use of large doses. He gives it in all cases of suspicious sore throat and has never had bad results. He remarked on the fact of often not finding the bacilli in undoubted cases of the disease.

Dr. Russell asked whether it were not well to begin the administration of stimulants early in the treatment and thus sustain the patient. Dr. McCulloch thought not, preferring to depend on the condition of the heart as an indication.

Dr. Tripp referred to the statement of Hare that the younger the child the larger should be the dose in proportion. He mentioned the case of a young adult in Boston who was reported to have received 40,000 units. He said complications do not contraindicate antitoxin and described a patient with bad heart murmurs who was given two doses of 2,000 units each, with good results.

Dr. Randell thought the question of stimulants important in this as in many other diseases. He believes there is a right time to use them and that both present and future harm may result from administering them too early.

Dr. Churchill mentioned the necessity of recognizing this disease in connection with others. He had recently had three cases of scarlet fever in which diphtheria appeared as a complication, with characteristic symptoms.

Dr. Smith raised the question whether the quarantine should be maintained till the absence of bacilli was proven by culture. This custom prevailed formerly with uniformity, but the bacilli can also be demonstrated in the throats of nurses and even physicians who are not quarantined. Some authorities follow the arbitrary rule of raising quarantine ten days after disappearance of clinical signs.

Dr. Sweeney called attention to the period of weakened heart action after the acute stage has passed, and the necessity of keeping the patient flat on the back at this time. He cited instances of sudden death from failure to observe this rule.

Dr. Marsh did not believe in immunizing other members of the family, claiming it is unnecessary and also difficult of accomplishment. The attending expense is a serious obstacle. The subsequent skin eruption in some cases and aggravation of existing eruption in others is a contraindication.

Dr. Miles wished to congratulate the essayist and others who had never lost a case. He had not been in that fortunate position. He related several instances of severe laryngeal cases, with other complications and death.

Dr. Hoffman wished to protest against treating so lightly the matter of immunization. He thought it ought to be insisted on, as being as important as vaccination for protection against small pox.

PIERCE COUNTY MEDICAL SOCIETY.

President, C. Quevli. M. D.; Secretary, A. de Y. Green, M. D.

The regular monthly meeting of the Pierce County Medical Society was held at the "Private Sanitarium," 104 South Tacoma Avenue, Tacoma, Wash., on the evening of March 15, 1904, President Quevli being in the chair.

Applications for membership of Dr. John J. Sturgus, of Vashon; Dr. Spencer and Dr. Frank Scott, of Tacoma, were read.

Dr. Lowell, of Tacoma, and Dr. Douglas, of Puyallup, were elected to membership.

Dr. Yocom suggested that the members save their medical literature, as the City Librarian has promised an alcove in the city library for its use by the medical profession.

Dr. Sargentich read an excellent paper and discussed fully the methods of examination, location, size and capacity of the stomach; inspection, palpation, various sounds, noises and methods of exciting same; gastroscopy and illumination. Dr. Sargentich deserves great credit for thoroughness and extent of which he took up his subject.

Dr. C. R. McCreery made practical demonstrations of motor and secretory function and absorption; also chemical examination of the stomach secretion and contents. Dr. McCreery, by the capable manner in which he handled his subject, held the strictest attention of his audience the entire time.

The meeting adjourned about 10:30 to enjoy the sumptuous feast prepared by the hostesses, Miss Dakin and Miss Beck.

The members were more than pleased with the new Sanitarium and prophesied great success for its future.

SNOHOMISH COUNTY MEDICAL SOCIETY.

President, C. A. Mead, M. D.; Secretary, James Chisholm, M. D.

The annual meeting of the Snohomish County Medical Society was held at Everett, at 8:30 P. M., February 2, 1904. In the absence of the President and Vice-President, W. C. Cox occupied the chair. The minutes of the last meeting were read and approved.

PAPERS AND DISCUSSIONS.

The History of the Treatment of Gonorrhea with Special Reference to the Lines along which Improvements may be anticipated. Dr. S. S. Peterkin, of Seattle, read this paper, which was received with much interest and general discussion.

Post-Mortem Work. Dr. Burns, of Seattle, delivered an able and interesting address on this subject, and especially urged the necessity of all physicians making scientific autopsies, lest they lose one of their principal methods of increasing their knowledge of disease and their diagnostic ability.

On motion of Dr. Chisholm, a cordial vote of thanks was tendered to Drs. Burns and Peterkin.

The regular monthly meeting of Snohomish County Medical Society was held in Everett, on Tuesday evening, March 8, 1904. The President, Dr. C. A. Mead, occupied the chair.

CLINICAL CASES.

Undescended Testes. Dr. W. C. Cox, of Everett, presented a very interesting case of this condition, in a young boy aged eight years, having a history as follows: At the age of nine months, he developed a double inguinal hernia, which was easily reduced, and the child was subsequently fitted with a truss. At the age of eighteen months, herniae again appeared on both sides, and could only be reduced after a great deal of manipulation and considerable difficulty. A truss was again fitted carefully, but at this time it was discovered that the testes were absent from the scrotum. The father of the child stated positively that the tests were in the scrotum previously to the second appearance of hernia and, in his opinion, disappeared simultaneously with the hernia.

This case proved to be the subject of a very interesting discussion, in which all members took an active part.

Concealed Pneumonia. Dr. Jas. Chisholm reported a somewhat interesting case of Concealed Pneumonia, in a boy aged sixteen years, who during convalescence developed a pneumonic abscess, and subsequently a very severe condition of typhoid fever.

PAPER.

Bone Surgery. Dr. C. A. Mead, Everett, presented the subject of Bone Surgery, in an able, interesting, yet somewhat novel manner; and so logical were his arguments, that his hearers were convinced beyond a question of doubt.

Dr. Mead also made a pleasing reference to the very cordial reception which he received at the hands of the Pierce County Medical Society, while in attendance at their annual banquet in Tacoma, on Tuesday evening, March 2.

On motion, the Society adjourned, to meet again on the first Tuesday in April.

WHATCOM COUNTY MEDICAL SOCIETY.

President, D. E. Biggs, M. D.; Secretary, W. N. Hunt. M. D.

The Whatcom County Medical Society met in regular monthly session Monday evening, March 14, 1904, in Bellingham, Wash., with Dr. D. E. Biggs, President, in the chair.

On motion of Dr. Van Kirk, the President was authorized to appoint a committee of five members to confer with the Committee on Sanitation of the charter commission, regarding matters of interest to the profession in framing a charter for the new city of Bellingham.

As such committee the chair named Drs. Holt, Van Kirk, Axtell, Kirkpatrick and Hunt.

PAPERS AND DISCUSSIONS.

Gonorrheal Opthalmia; Acute Specific Urethritis. Dr. F. J. Van Kirk presented a paper on Gonorrheal Opthalmia, and Dr. S. H. Johnson, one on Acute Specific Urethritis, both of which covered the ground indicated by their titles in a thorough and exhaustive manner.

The papers were illustrated by microscopic specimens of gonococci, representing different stages of gonorrnea.

All present participated in the discussion which followed.

Adjourned to meet the second Monday in April.

SILVER BOW COUNTY MEDICAL ASSOCIATON.

President, T. J. Murray, M. D.; Secretary, Grace W. Cahoon, M. D.

A meeting of the Silver Bow County Medical Society was held at Butte, Mont., March 9. The following officers were elected for the ensuing year: President, T. J. Murray; Vice-President, Ignatius Donnelly; Secretary, Grace W. Cahoon; Treasurer, S. A. Gregg; Trustees, T. J. Murray, J. D. Freund, J. W. Gunn, D. Campbell and I. Donnelly. After the regular meeting, March 23, a Dutch lunch was served in honor of the retiring president, T. J. Sullivan. W. L. Renich was elected delegate to the State Association which meets at Butte, May 17 and 18.

RECENT PROGRESS IN MEDICINE AND SURGERY.

INTERNAL MEDICINE.

Edited by

C. W. Sharples, M. D.; H. M. Read, M. D.

A Report of Ten Cases of Pneumothorax Occurring in Pulmonary Tuberculosis. By J. W. Trask, M. D., Journ. A. M. A., March 5, 1904.

Dr. Trask reports these cases as a complication of consumption in a sanitarium located at Fort Stanton, New Mexico. Out of a total number of forty-one deaths in nine months at this sanitarium, which is especially intended for the treatment of consumptives, nine were from this accident, and one case of pneumothorax was still living.

Fort Stanton is situated 6150 feet above the sea level and to this fact he attributes the possibility of the frequency of pneumothorax in consumption at that location, on the basis that the increased exertion of the lungs necessary to inspire the essential amount of oxygen may be responsible for the rupture of the thin wall of the tubercular cavity, and also for the fact that the complication is fatal as rapidly and as often as it seems to have been in a number of his cases.

He calls attention to the fact that four cases ended fatally as an immediate and direct result of the perforation of the lung and the formation of the pneumothorax, which is really a very large number considering that pneumothorax is generally a condition which lasts for some time after its occurrence, and before death is usually associated with the formation of pus, forming a pyo-pneumothorax.

One patient reported that he felt pain in a very marked degree as though something had burst in his side and died cyanosed in an hour and ten minutes time. Another patient died in an hour and a half after he felt the pain, and another in three days.

It is well to remind ourselves occasionally of such conditions and to recall that hemorrhage is not the only cause of sudden death in consumption, for the shock of perforation of the lungs into the plural cavity has caused almost instantaneous death. and also this should admonish us that it is very unsafe to allow people with large cavities in the lung to go to high altitudes, on account of the possible tendency of the increased exertion necessary for proper respiration to produce a perforation, and also to cause all those people who may have pneumothorax to avoid high altitudes.

The ordinary percentage of pneumothorax is four and one-half to ten per cent. The symptoms of the occurrence of perforation are sudden attacks of pain, intense, sharp and oppressive dyspnea, general cyanosis and rapid, feeble pulse. Sharples.

Headache from Non-Suppurative Inflammation of the Accessory Sinuses of the Nose. By Charles M. Robertson, M. D., Journ. Am. Med. Assn., March 5, 1904.

Dr. Robertson calls attention to this condition which may be caused by swelling of the mucous membrane, by an effusion of lymph in the cavity, or by engorgement of the mucous membrane itself by lymph.

Dr. Robertson reasons that the pain is produced by the reaction of or diminution of air pressure in the nose and cavities, for the imprisoned air loses its oxygen by absorption and the swelling prohibits the proper or free exchange of air in these cavities. It is similar to earache caused by a stoppage of the eustachian tube.

He reports two cases, exemplifying the condition. (If the doctor's theory is correct, there seems to be a previously overlooked cause of headache and worthy of due consideration. Possibly we may have considered it when we have told our patient that the headache was due to catarrh, though no one had previously proposed the cause—C. W. S.). SHARPLES.

The Tuberculous Serum Reaction.—By Drs. Osler and Thayer, Am. Journ. Med. Sciences, March, 1904.

The writers review the recent work done in the clinic of Professor Grocco, of Florence, as to the value of the tuberculous serum reaction. The Italian authors studied the reaction in seventy-three cases. They emphasize the necessity of using cultures of carefully determined age and of following minutely, in every detail, the methods of Arloing and Courmont. The results of their studies are as follows:

They believe the reaction is of no material value unless positive in the first six hours.

In grave tuberculosis, pulmonary or abdominal, the reaction was positive in 42 per cent. of the cases.

In early cases, mild or improving, the reaction was positive in 88 per cent. of the cases. In cases which were probably tuberculous but which chemically could not be positively determined, the reaction was positive in one out of four of the grave cases, and in two-thirds of the milder forms of disease.

In three cases of lupus the reaction was negative.

In five cases which were proven by autopsy not to have been tuberculous the reaction was always negative.

In general, the milder the lesion the more positive the reaction, while in one case, where the reaction was primarily positive, it disappeared as death approached (tuberculous meningitis).

For six hours the reaction may be positive in clearly nontuberculous cases.

They conclude that the Arloing-Courmont reaction, studied accurately and minutely and weighed with all due restrictions, is a useful and not to be neglected diagnostic aid, especially in early and mild cases, in which the percentage of positive results are the largest and most striking. These cases are the very ones in which from point of prophylaxis and treatment, the early recognition of the process is of especial value. READ.

Cause and Treatment of Chronic Rheumatism.—By Stockman, Brit. Med. Journ., February 27, 1904.

The author does not hold that chronic rheumatism so called bears any relation to acute rheumatism, which he regards as an acute microbic infection, running a regular course; that it can no more become chronic than typhoid fever or any acute infection. The name is used because it has so long been taken to describe special joint conditions of which there are many varieties, and in true cases of chronic rheumatism the parts implicated are the fibrous ligaments of the joint, and more particularly the fibrous tissues of the muscles and bones.

The pathologic changes, he states, are confined to the white fibrous tissue. Muscle movement aggravates the pain by causing pressure on the swollen tissues. This swelling can often be felt at exposed places. These swellings are a common accompaniment and sequelae of acute rheumatism and persist after the disappearance of the acute attack. These conditions may come after influenza and febrile diseases.

He believes that chronic rheumatism is not a diathesis, but a local disease of the fibrous tissue, the result of a number of causes.

The symptoms are well known. The treatment of the acute exaccerbations by massage, baths, salicylates, etc., may be of temporary value, but, to obtain permanent results, the indurations must be obliterated. He states that the only means he has found of special and lasting value has been massage, faradism and exercise. Residence in a dry climate may effect a cure. Certain nodules, when not too near the skin, may be injected with one per cent. solution of chromic acid, provided the needle can be put into the center of the nodule, and certain other nodules which remain sore in spite of other treatment may be removed surgically with complete relief.

In recent cases the prognosis is good and prolonged treatment may cure. old cases. Even in incurable old cases much good can often be done by massage and stretching manipulations. READ

BOOK REVIEWS.

Edited by
KENELM WINSLOW, M. D.

Progressive Medicine, Vol. I, March, 1904. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, 337 pages, 7 illustrations. Per annum, in four cloth-bound volumes, $9.00; in paper binding, $6.00, carriage paid to any address. Lea Brothers & Co., Publishers, Philadelphia and New York.

The first issue of Progressive Medicine this year appears in a new garb of yellow paper, resembling many of the familiar German publications, but is now published at $6.00 instead of $10.00 as formerly. The cloth bindings can still be procured but, as the publishers state, the cost of the Quarterly has been materially reduced and one can bind it to suit oneself. We have already said in these columns before, that we regard Progressive Medicine as the most excellent of all the quarterlies and annuals recording advance in the medical sciences, including all the specialities; that the contents consists not merely of abstracts from new articles thrown heterogenously together, but the whole domain of medicine is separated into departments and each department is edited by an authority who not only uses wise discretion in selecting new matter for his subject, but critically comments on such matter with the wisdom of his experience and knowledge. It is a work alike for the generalist and specialist, and in its volumes will be fonnd mirrored the progress of medicine, while the older files record the history of modern medicine. In the present issue of 337 pages are considered, The Surgery of the Head, Neck and Thorax; Infectious Disorders; Children's Diseases; Laryngology, Rhinology and Otology. Among subjects to which special attention is given are Cerebral Pressure, in which it is pointed out that increased intra-cranial tension gives rise to cerebral anemia and this, in its turn, stimulates up to a certain point, the vasomotor centres and general blood-pressure. Therefore high, general, blood-tension in brain injuries is an important indication for operative interference.

Abbe presents 42 cases of mammary cyst and points out the distinguishing feature of scirrhus as separated by its position—between the nipple and axilla—from cyst which may occupy the breast generally. He advocates aspiration for diagnosis and cure, reporting but two recurrences after this treatment. He differs from recent advices to remove the breast subcutaneously in cyst for fear of future malignancy. Koch recommends the method of Drigolski and Conradi by which stools of suspected typhoid are inoculated into culture media stained with litmus, the acid-forming colonies of the colon bacillus contrasting strongly with the alkaline colonies of typhoid bacilli. By this method a diagnosis may be made in the first days and in cases not presenting recognized clinical features. Among the host of subjects worthy of attention Heart Surgery, the treatment of Tic Douloureux and Exophthalmic Goitre, the Transmission of Diseases by Insects, the Etiology of Acute Rheumatism, Tetanus and Paratyphoid, and modern ideas concerning the Nature of Hay Fever are given special study. An interesting account of a girl swallowing a virulent typhoid culture from a laboratory—with suicidal intent—is recorded. The incubation was but three days and she passed through the usual course of the disease with recovery. WINSLOW.

Fischer—Infant-Feeding in Its Relation to Health and Disease. A Modern Book on all Methods of feeding. For Students, Practitioners, and Nurses. By Louis Fischer, M. D., Visiting Physician to the William Parker and Riverside Hospitals, of New York City; Attending Physician to the Children's Service of the New York German Poliklinik; Former Instructor in Diseases of Children at the New York Post-Graduate Medical School and Hospital; Fellow of the New York Academy of Medicine, etc. Third Edition, Thoroughly Revised and Largely Re-written. Containing 54 Illustrations, with 24 Charts and Tables, Mostly Original. 357 pages. $5\frac{3}{4}$x$8\frac{3}{4}$ inches. Neatly bound in Extra Cloth. Price, $2.00, net. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

This well known work has reached its third edition in the present issue. It is a most thorough exposition of the chemistry and physical properties of milk—cow and human, and also goes into the anatomy and physiology of the infant's digestive organs. The exhaustive character of the book is illustrated by recording cases of nursing of infants by human males. Every detail of bottle and artificial feeding is considered, forced feeding, feeding in diphtheria, rectal feeding, feeding with cleft palate, and in many of the common diseases of infancy. While Fischer records the various plans for the home modification of milk, yet he leans to the much-to-be-desired simplicity, and his own methods are simplicity itself. The Walker-Gordon laboratory milk, and milk depots for the distribution of pure milk to the poor are described, and altogether there is not a more complete treatise on the subject in English, and we heartily recommend it to the general practitioner. WINSLOW.

The Medical Epitome Series. Microscopy and Bacteriology, by P. E. Archinard, A. M., M. D., 221 pages. 74 engravings. Physiology, by Theodore C. Guenther, M. D. 255 pages. 57 engravings. Obstetrics, W. P. Manton, M. D. 265 pages. 82 engravings. Genito-Urinary and Venereal Diseases, by Louis E. Schmidt, M. Sc., M. D. 249 pages. 21 engravings. Lea Bros. & Co., Philadelphia and New York.

These little manuals, bound in red cloth and of uniform size, 7x5¼ inches, are edited by V. C. Pederson, A. M.; M. D., and cover the whole realm of medicine, containing the maximum amount of information crowded into the minimum of space at the smallest price. While peculiarly adapted for student's use, they will prove valuable for the general practitioner for easy reference and to supplement extensive treatises on special subjects by bringing them up to date at a small cost. While there are questions arranged for students ,these are placed at the end of the chapters, and so do not interfere with the text. For completeness, and concise, and clear condensation, these epitomes of medical knowledge attain to as high a degree of excellence as any similar publications we have seen. WINSLOW.

REPORT OF CONTAGIOUS DISEASES.

To the Washington State Board of Health for February, 1904.

Counties.	Smallpox		Scarlet Fever		Diphtheria		Typhoid Fever	
	Cases	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*
Adams	0	0	5	0	1	0	0	0
Chehalis	0	0	2	0	4	1	3	0
Clarke	1	0	2	0	0	0	0	0
Columbia	0	0	7	0	0	0	0	0
Cowlitz	0	0	0	0	0	0	2	0
Douglas	0	0	2	0	0	0	0	0
Jefferson	0	0	0	0	1	1	1	1
King	4	0	15	1	3	0	0	0
Kitsap	0	0	7	0	3	0	0	0
Kittitas	0	0	10	0	0	0	0	0
Lewis	1	0	2	0	0	0	0	0
Lincoln	0	0	9	0	0	0	4	0
Pacific	1	0	0	0	0	0	0	0
Pierce	5	0	0	0	0	0	1	0
Skagit	1	0	1	0	2	1	0	0
Spokane	0	0	8	0	1	1	0	0
Thurston	2	0	1	0	0	0	3	0
Wahkiakum	0	0	0	0	0	0	1	0
Whatcom	17	0	7	2	8	1	0	0
Whitman	0	0	2	0	2	0	0	0
Yakima	0	0	0	0	12	3	2	0
Seattle (city)	5	0	75	0	12	2	11	2
Spokane (city)	8	0	4	1	9	1	8	4
Tacoma (city)	1	0	2	0	2	0	8	6
Total	46	0	167	4	60	11	44	13
Total, Feb., 1903	99	0	65	0	6	0	0	0
Total 1904	92	1	311	0	202	29	130	29
Total same period 1903	191	0	128	0	30	0	0	0

ELMER E. HEG, Secretary.

MEDICAL SOCIETIES.

Name. Meetings Held.

Washington State Medical Association.........July 12, 13, 14—Seattle
President, F. H. Coe, M. D.; Secretary, A. H. Coe, M. D.

Chehalis County Society ....Second Tuesday—Aberdeen
President, D. A. Schumacher, M. D.; Secretary, J. W. Scamell, M. D.

King County Society ....First and Third Monday—Seattle
President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

Pacific County Society ....
.............Third Monday of Jan., April, July, Oct.—South Bend
President, G. W. Overmeyer, M. D.; Secretary, Mary W. Gunwell, M. D.

Pierce County Society.............First and Third Tuesday—Tacoma
President, C. Quevli, M. D., Secretary, A. de Y. Green, M. D.

Skagit County Society ....
President, A. C. Lewis, M. D.; Secretary, R. J. Cassel, M. D.

Snohomish County Society..................First Tuesday—Everett
President, C. A. Mead, M. D.; Secretary, James Chisholm, M. D.

Spokane County Society...................First Thursday—Spokane
President, G. S. Armstrong, M. D.; Secretary, Geo. A. Gray, M. D.

Walla Walla County Society.........Second Wednesday—Walla Walla
President, N. G. Blalock, M. D.; Secretary, Y. C. Blalock, M. D.

Whatcom County Society.................Second Monday—Whatcom
President, D. E. Biggs, M. D.; Secretary, W. N. Hunt, M. D.

Whitman County Socity.........Third Monday of Jan., Apr., July, Oct.
President, W. N. Divine, M. D.; Secretary, R. J. Skaife.

Yakima County Society.............First Tuesday—North Yakima
President, David Rosser, M. D.; Secretary, Carver, M. D.

Oregon State Medical Association.....................1904—Portland
President, W. T. Williamson, M. D.; Secretary, L. H. Hamilton, M. D.

City and County Medical Society of Portland...First Wed.—Portland
President, R. L. Gillespie, M. D.; Secretary, A. D. Mackenzie, M. D.

Multnomah County Medical Society..........First Tuesday—Portland
President, A. Tilzer, M. D.; Secretary, L. Victoria Hampton, M. D.

Montana State Medical Association...........May 17 and 18—Butte
President, L. Bernheim, M. D.; Secretary, B. C. Brooke, M. D.

Silver Bow Medical Society....Second and Fourth Wednesdays—Butte
President, T. J. Murray, M. D.; Secretary, Grace W. Cahoon, M. D.

Idaho State Medical Association...........October 6 and 7—Lewiston
President, J. L. Conant, Jr.; Secretary, E. E. Maxey, M. D.

Northern Idaho District Medical Society.............June 9—Lewiston
President, C. L. Gritman, M. D.; Secretary, C. D. Parsons, M. D.

Southern Idaho District Medical Society...............April 7—Boise
President, W. E. Hargrave, M. D.; Secretary, R. E. Smith, M. D.

Canadian Medical Association...........Aug. 23, 24, 25—Vancouver

British Columbia Medical Association..............1904—Vancouver
President, A. P. Procter, M. D.; Secretary, W. D. Brydone-Jack, M. D.

Vancouver Medical Society ....Vancouver
President, W. D. Brydone-Jack, M. D.: Secretary, J. S. Conklin, M. D.

Corrections and additions to this list are requested from societies reached by this journal.

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NAME.	QUALIFICATION.
BAKENHUS, MISS MELINDA	Graduate Bethesda Hospital, Chicago.
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BEAN, MISS ALTA	Graduate Grace Hospital, Detroit.
BECHDOLT, MISS MARGARET	Graduate Seattle General Hospital.
BENDER, MISS JULIA M.	Graduate Illinois Eeastern Hospital.
BLASHFIELD, MISS ELLA	Graduate U. B. A., Grand Rapids, Mich.
BRYSLAND, MRS. LILLIAN	Graduate Seattle General Hospital.
BUTTON, MISS AUGUSTA	Graduate Seattle General Hospital.
CROWL, MISS FLORENCE I.	Graduate Seattle General Hospital.
CUTHBERTSON, MISS JEANETTE	Graduate Wisconsin General, Milwaukee.
DAM, MRS. EVA L.	Graduate Seattle General Hospital.
DEVECKMON, MRS E.	Graduate Seattle General Hospital.
FEEHAN, MISS ANNA	Graduate St. Joseph's Hospital, St. Paul.
GILLESPIE, MISS CORA E.	Graduate Ill. Training School, Chicago.
GREEN, MRS. ANNA G.	Graduate Good Samaritan Hospital, Portland.
GRIMES, MISS EVA	Graduate City Hospital, Minneapolis.
GROVAN, MISS MOLLIE	Graduate Seattle General Hospital.
HEMPEL, MISS CLEO	Graduate Colorado Training School, Denver.
HERDMAN, MISS LILLIAN E.	Graduate Seattle General Hospital.
HOLMES, MRS. MINNIE GREGG	Graduate Women's Hospital, Syracuse, N. Y.
HUBBS, MRS. F. H.	Graduate Philadelphia Hospital.
HUGHES, MISS M. A.	Graduate Dublin General Hospital.
HUMPHREYS, MISS ALICE LLOYD	Graduate Fabiola Hospital, Oakland, Cal.
KAPP, MISS W.	Graduate Orange Memorial Hosp Orange., N. J.
KENNEDY, MISS	Graduate St. Luke's Hosp., Duluth. P. G. Sloan Maternity.
KRANZ, MRS..	Graduate Bethesda Training School.
LACKOORE MISS LILLIAN	Graduate Wesley Hospital, Chicago.
LAEMMERICH MISS LOUISA	Graduate Winona General Hospital.
LAPORTE, MRS. ELIZABETH	Graduate Cincinnati Hospital.
LIVERMORE, MRS. AGNES B.	Graduate Winona General Hospital.
MAJOR, MISS KATHERINE	Graduate Cincinnati Hospital.
MATHESON, MISS CHRISTINE	Graduate New England Hospital Training School fo Nurses.

Graduated Nurses' Directory--Continued

McCALLUM, MISS MARY	Graduate St. Mary's Hospital, Rochester, N. Y.
McGREGOR, MISS HATTIE	Graduate Seattle General Hospital.
MURRAY, MISS ISABELLE	Graduate Seattle General Hospital.
NEWTON, MISS G. W.	Graduate Royal Jubilee Hospital, Victoria.
RAY, MISS JENNIE Z.	Graduate Seattle General Hospital.
RUST, MISS ALICE	Graduate Church Home and Infirmary, Balt.
SCHROEDER, MISS H. L.	Graduate Seattle General Hospital.
SHIACH, MISS MARY	Graduate Seattle General Hospital.
SLATER, MISS GRACE	Graduate Illinois Eastern Hospital.
SMITH, MISS ABBIE	Graduate City Hospital, Worcester, Mass.
SMITH, MISS ISABELLE	Graduate Danver's Insane and Boston City Hospitals.
STRAHL, MISS INEZ	Graduate Asbury Hospital, Minneapolis.
STRONACH, MRS. MINNIE	Graduate Brompton Hospital, London.
TAYLOR, MISS HELEN M.	Graduate General Memorial Hospital, N. Y.
THORNE, MISS	Graduate Farmington Training School, Mass.
UNDERWOOD, MISS MARGARET	Graduate Buffalo General Hospital.
WAGNER, MISS IDA	Graduate Riverside Hospital, Milwaukee.
WALTON, MISS HATTIE	Graduate Seattle General Hospital.
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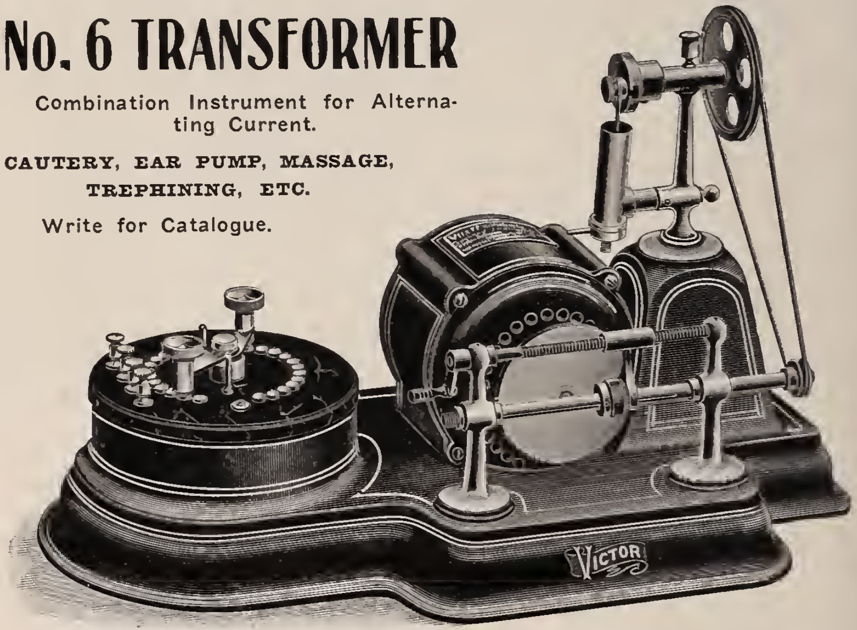

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1858--1904

NORTHWEST MEDICINE

May, 1904.

ORIGINAL CONTRIBUTIONS.

SOME CHARACTERISTICS OF EASTERN AND EUROPEAN CLINICS.*

By L. P. McCalla, M. D.,
BOISE, IDAHO.

In attempting to give you a resume of my year's work in the East and abroad, which came to an end last September, I trust I may do so to your interest in the brief survey which a short time only will allow. I trust I may not shock those of you who may already be familiar, and others who may become so, with the medical centers of Europe, by giving misrepresentations from hearsay, as some physicians have done, in giving accounts of the great men and their work in Europe. In reading, recently, a report of this kind I was surprised at some of the personal descriptions given and comparisons drawn, which showed conclusively that the party had never seen the men he was describing. I shall only touch briefly on the points of main interest as they appeared to me, of each locality, it being impossible to do more in a short paper like this.

My first stop was in Chicago. There are some of the greatest medical men of the world in Chicago, as you all know. For operative ability, profound learning and ability to teach to others, Murphy, Senn and Ochsner are great men. They do a great deal of work, and do it well. John B. Murphy is one of the world's greatest surgeons. He possesses all the requisites of a great surgeon. He has done as much original work, is as learned and is as able an operator as any surgeon in America.

The most interesting work I saw in Chicago was the prostatectomies by perineal route, the gastroenterostomies by various methods, the gastrectomies and gallbladder operations, as done by the three men mentioned above. This work in the upper part of the abdomen is attracting more attention now than all other surgical work in all surgical fields. There has been more learned about operations for stomach, gallbladder and prostate glands in the past three years than was ever known before. Carcinomas of the stomach are now being diagnosed by a few men early enough to give a fair hope for at least as great a percentage of cures as is obtained today in carcinomas of the uterine cervix. To fail to make the diagnosis of carcinoma of the stomach until a tumor can be felt is to fail to learn the patient's condition early enough to offer any possibility of cure to him. To treat these cases for catarrh of the stomach until the disease has got beyond complete removal is a gross diagnostic error and has cost your patient the only chance for saving his life.

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*Read before the Southern Idaho District Medical Society, Boise, Idaho, April 7, 1904.

To allow a diseased gallbladder to go until the patient is profoundly jaundiced, and until he has a tumor which can be felt by the fingers is, to say the least, giving your patient mighty poor care, and allowing him to suffer and run risks of losing his life which should not have been the case. How comparatively few gallbladder cases ever give the classic text book symptoms. The cases which need surgical relief most are the very ones that never have jaundice nor have a tumor. Those who have large gallbladder tumors are only too often malignant and beyond the pale of the surgeon.

The old men who are allowed to get badly run down and poisoned from the bladder trouble due to enlarged prostate, until they no longer have any resistance, who are septic and frail, all because the trouble was not diagnosed early or only treated with the use of the catheter, are now very poor operative subjects, and, without operation, are surely doomed to die a death of fiendish torture, being victims of poor judgment and badly treated. The time has come when a patient, allowed to lose his chances for cure by this kind of treatment, is going to call down upon the head of the surgeon as much odium as for neglect of an acute appendicitis case, or the failure to remove a carcinoma of the breast until it has metastasized elsewhere. The route by which a diseased prostate is removed is still a much disputed point. The European surgeons nearly all use the suprapubic, while the Americans, generally now, are using the perineal. There are cases, however, in which all are agreed upon the upper route, those in which the enlargement is mainly intravesical, yet the coming operation in most of these cases is through the perineum.

Prof. Ball, of Dublin, Ireland, who was introduced by Murphy in Cook County Hospital while I was there, as the greatest authority on rectal diseases in the world, said he had never seen the perineal operation done until he saw Murphy do it, that day; but that he was convinced of its superior claims over the suprapubic operation in most cases, and that he would in the future follow this route. I had the fortune to see this great Irish surgeon do a number of operations on the rectum and bladder while he was in Chicago, also later in Dublin. He used the Kraske method in most rectal carcinomas, but refused to operate in one selected case, as he believed the best treatment was simple dilatation by bougies, as the disease had probably metastasized to the liver, as they so often do.

W. J. Mayo, who is one of the greatest surgeons of America, always does a combined abdominal and perineal operation on all carcinomas of the rectum. It is a most interesting sight to see Will Mayo operating through the abdominal route and Charley Mayo by the perineal route simultaneously on the same patient. Will Mayo says that he thinks it best to always open the abdomen, do a colostomy, then if the disease has not metastasized to the liver, completely remove the portion of gut below, in all carcinomas of the rectum. You will, by doing this, not operate to remove the gut when too late, as you will if the abdomen is not opened, and, too, a more complete operation can be done; and a colostomy should be done in all cases, as the patient is freer from pain, the wound heals quicker, and there is less danger of sepsis.

Nowhere in all my travels did I see as much or better surgery than in Rochester, Minn., by the Mayo brothers. Will Mayo is easily the best abdominal surgeon in America. No one has done as much nor as good surgery of the stomach and gallbladder as has he, in America. He urges strongly the necessity of recognizing the stomach carcinomas early, and always advocates early exploratory operation when in doubt, as the early recognition alone is the only chance for cure in these cases; and in gallbladder diseases early removal not only saves the patient much suffering and danger, and is a much easier and safer operation, but as one in twenty of these gallbladders becomes carcinomatous, its early removal offers the only chance of cure.

He removes all thickened, septic or shrunken gallbladders by cutting through the serous and muscular coats, at the juncture of the middle and upper thirds, down to the mucous membrane, which is stripped down to the neck and excised. A rubber drainage tube, covered with gauze and protective, is sutured by purse-string suture in the opening or neck, brought out through the incision, or a stab wound, and connected by another tube of glass and rubber to a bottle, which is covered by the bandage and removed as often as necessary when filled, thus keeping the patient clean and dry. When the gallbladder is not too much diseased and is long enough to be sutured to the peritoneum, a rubber tube, as before fixed, is sutured by purse-string suture, after turning the edges of the bladder in, thus bringing serous surfaces of gallbladder and peritoneum together, and draining as above described. About the tenth day the tube is ready to be removed, as the discharge has ceased, and as the catgut purse-string suture is absorbed, it is easily removed.

The plastic work of Chas. Mayo is the best I have ever seen. His harelip and neck operations are perfect. His operation for removal of varicose veins is unique and ingenious. Instead of making a long skin incision along the veins of the leg and thigh, he makes a few short. one-half inch incisions, about five to six inches apart. and passes a uterine sound along and around the vein. thus loosening it so it may be pulled down and out the lower incisions, until all is removed. and the leg is thus very little scarred and heals quickly.

My next stop was in Baltimore. where I feel very much at home, having previously spent a year there. The work of Welch, Osler, Halsted, Kelly, Bloodgood. Cullen and Williams is of course familiar to you all. I spent six months here, doing general work, two mornings each week being allotted to each clinical branch, medicine, surgery and gynecology, two afternoons each week allotted to the clinical laboratory, two to the surgical and two to the general pathology laboratories.

I believe that nowhere in an English-speaking country are better opportunities offered to the student of medicine than in Johns Hopkins. It is difficult to get in, except to the regular post-graduate course in the spring, but if you are lucky enough, you get the best opportunities known to me for the scientific and thorough study that is found in America. In internal medicine and diagnosis Osler is the superior of any man in the English-speaking countries. Even the English will admit this. His methods of teaching, by bedside and clinic, have come to supplant the old didactic teaching and is the better way by all means. He brings together in clinics several cases of the same disease, and thus shows the different phases of it. Osler's faculty of remembering the work and writings of other men is marvelous. So often while speaking of a case he will recall something, written perhaps years before, by some physician, and which is brought to mind by the patient in question. He has the faculty of remembering not only the similar point in the case, but the name of the writer and where it can be found. Dr. Osler is a good pathologist, and a great diagnostician. No one questions his diagnosis, and every one holds him in profound respect who knows him.

Dr. Halsted is a profound man in pathology and has great diagnostic ability. His clinics are fashioned after the German style, and are always most instructive and interesting. His breast carcinoma work is enough to immortalize him. He has brought the percentage of cures from 15 to nearly 70 per cent. His work, too, has done much to discourage the rapid gallery play surgery so much vaunted in New York and other places, and now the best surgeons are not making time records, but are trying to make low mortality records and to obtain the best results. These results are not obtained by the rapid operator, but the painstaking and thorough man.

Dr. Kelly's clinics are brilliant from an operative standpoint, and the man is unquestionably a genius. Kelly is not popular abroad.

Nowhere in all my travels have I seen any one teaching surgical pathology [illegible] a special branch, as Dr. Bloodgood is doing; and nowhere have I seen it taught so well. All the German surgeons teach surgical pathology, but only in the regular clinics, much as Dr. Halsted does, but the special study is nowhere else taught as they are doing. You will find in nearly all the European schools gynecologic pathology taught as a specialty, but surgical pathology, which is of far greater scope and importance, is not a specialty. Dr. Bloodgood is fast becoming known everywhere as a profound man, and he commands the respect of all who know him well. I feel that my six months' study of surgical pathology in Dr. Bloodgood's laboratory was of more benefit to me than all else I learned during this year's work.

Dr. Welch practically stands alone in the English-speaking countries as a teacher of bacteriology and pathology. I feel well repaid for the hard work done in the two years' courses I have taken in his laboratories. I sincerely regret that this opportunity did not come to me early in my study of medicine. I have been far better satisfied with my work since having gotten this further insight, which is about as Dr. Welch aptly remarks in his lectures, that a thorough knowledge of pathology distinguishes the scientific physician from the medical tradesman, and every one who has had this training feels that many of the mists which clouded his poor tired brain have been lifted, and, although he now feels further from the perfect physician he had hoped to be, he is still stimulated to keep on trying to at least reach some of the low levels that have been trod by better men than he.

Dr. Cullen's course in gynecologic pathology, which I have twice gone through, is a good thing and is most helpful in the diagnosis of uterine scrapings, etc., and will often reward you by helping to make an early diagnosis in time to save your patient who has beginning carcinoma, tuberculosis, etc. One of the best courses I had while in Baltimore was that in blood given by Dr. Chas. Simon. His teaching is in personal contact and instruction, and he certainly does his work most satisfactorily and to the entire satisfaction of all his students.

After leaving Baltimore we made a short stop in Philadelphia. While there I had the pleasure of seeing the great surgeon from Halberstadt, Prof. Kehr, who has done more gallbladder surgery than any other man in the world. He makes very long incisions, works very slowly and carefully, and is now quoted by every surgeon as being the authority on this subject. He has reported about eleven hundred of these cases. He is a heavy, stout man, and has hard work to make himself understood in English. He scrubs his hands half an hour with stiff brush, soap and water, then the usual antiseptic soakings, ending with ether and alcohol.

Prof. Kehr closes his abdominal wounds with interrupted sutures and places them at least one and a half inches apart. He remarked that no doubt all who saw him close his wounds in this way would expect him to have a big percentage of herniae, but says that he has far fewer now than formerly, when he used more sutures. Personally, while I felt far from competent to criticise a man of such reputation and ability, I could not be convinced that his was a good method of closing abdominal incisions.

(*To be Continued.*)

A CASE OF ANKYLOSTOMIASIS, WITH NOTES ON THE DISEASE.*

By J. W. Thomas, M. D.,
SEATTLE, WASH.

R. W. T., male, white, age 28. Birthplace, Bedford, Iowa.

Family History—Father and mother alive and well. Three brothers well. Two sisters well and two died in infancy.

Personal History—Had parotitis, rubeola, varicella during childhood; had attack of malaria at twenty years of age, while spending some time in New Orleans. No venereal history.

He was born and reared on a farm until seventeen years of age, when he began attending high school, but spent his vacation on the farm; he spent a few months in New Orleans in '96; then returned to Iowa, taught school for a time and entered college in '97; enlisted in volunteers, June, '98, and sailed from San Francisco Nov. 3. After cruising around the Philippine Islands for a time he landed at Cavite on February 1, '99, and was ordered to firing line April 1. On August 15 was taken sick and sent to the hospital one week later; was discharged in San Francisco Nov. 2. He went home to Iowa and started to college January, 1900. In 1901 his health, which had been poor since August, 1899, became worse, and he was compelled to leave school in May, 1902. Not being able to resume his college work in the fall of '02, he coached the foot-ball team; took up his studies Jan. 1, '03, but had to drop out on the 1st of May. He came to Seattle in June and began doing office work here in September. This was continued until Feb. 1, '04, when he gave up his work.

While in the Philippines he had an attack of gastritis, in March, 1899, which he attributed to canned salmon. In June he began having diarrhea and gastritis, which became so severe he was sent to the regimental hospital at Manila, in August, with chronic diarrhea and gastritis. He did not stay in hospital long, as it was crowded with fever cases, but was kept in quarters under care of the regimental surgeon, being also under his care on the transport as he returned home. He began improving soon after landing at San Francisco, which continued for a time after reaching his home in Iowa, during the winter, but when the warm weather came he began going down; had headache, short breath, constipation or diarrhea all the time, though the symptoms were much exacerbated during the warm weather. He was troubled with insomnia, often being unable to sleep at all two nights a week. At one time the blood vessels of arms and limbs were enlarged. In

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*Read before the King County Medical Society, Seattle, Wash., April 4, 1904.

January, '03, his limbs began to swell. He had an attack of sciatic rheumatism of right limb of one months' duration.

Symptoms when he presented himself, Feb. 9, '04, were shortness of breath, coldness of extremities, headache (occipital), weakness, stomach easily disturbed, often having pain in that area, palpitation, alternating constipation or diarrhea.

Physical Signs—Lemon yellow color, which did not involve sclera; body apparently well nourished, but on palpating muscles were found flabby; pulse 90, which on least exercise, as walking across the room, would increase to 100 or above; general diffuse hemic cardiac murmur, systolic in time with the point of greatest intensity at pulmonary cartilage, transmitted to vessels of neck; edema of feet and legs. Sent patient to Seattle General Hospital with request that his blood, urine and feces be examined.

Feb. 11. Blood: Hemoglobin 20%, erythrocytes 1,470,000, leukocytes 7,400. Urine: Nothing abnormal. Feces: Numerous ova of ankylostoma duodenale.

After a fast of twelve hours gave thymol gr. xxx. repeated in four hours, followed four hours later by magnesium sulphate, oz. 1.

Feb. 13. After a fast, thymol gr. xxx. repeated four hours later. followed by magnesium sulphate, oz. 1.

Feb. 14. Liquor potassii arsenitis, m. 5 after meals; increased the dose as tolerated. Feces showed numerous ova and ankylostoma duodenale present.

Feb. 17. After a fast of twelve hours gave thymol, gr. xxx, repeated in four hours, followed by magnesium sulphate, oz. 1.

Feb. 18. Feces showed ova present.

Feb. 19. Pilulae ferri carbonatis, gr. v, t. i. d.

Feb. 26. Oleoresin aspidii, dr. 1. after fast of twelve hours, followed by calomel, gr. 1-5 every fifteen minutes for six doses, then by magnesium sulphate, oz. 1.

Feb. 29. Very few ova present in feces.

March 1. Blood, hemoglobin 40%; erythrocytes 3,360,000.

March 3. After a fast of fourteen hours, thymol, gr. xxx, at 11, 1, 3, followed at 5 by calomel, gr. 1-4 every fifteen minutes for eight doses; at 7:45 magnesium sulphate, oz. 1; at 9, oleum ricini, oz. 1.

March 7. No ova found in feces.

March 8. Blood, hemoglobin 50%; erythrocytes 4,100,000. Discharged from hospital.

March 9, 12, 21, 26, April 2. Nothing found in feces.

Stiles[1] says: "In connection with the symptoms let us recall that uncinariasis is caused by hookworms, about a half inch long, which live in the small intestine for several meters below the stomach.

"These worms fasten to the mucosa and suck blood. They lay numerous eggs, which can be found by a microscopic examination of the stools. The number of eggs in the feces and, in a general way also, the severity of the symptoms will vary with the number of parasites present and with the duration of the infection.

"The injury to the patients results from the following factors: (1) Sucking of blood by the parasites, which is a constant drain on the system; (2) loss of blood into the intestine through the minute wounds made by the parasites, a factor which also tends to deplete the system; (3) the wounds form points of attack for bacteria, hence increase the chances of bacterial infection as well as of toxic infection from partly digested and decomposed food; (4) the wall of the duodenum and jejunum becomes thickened and degenerated and its function is thus decidedly interfered with; (5) the parasites in all probability produce a poisonous substance which acts upon the patient.

"Theoretically there is only one sign which is present in every case, namely, the presence of one or more parasites in the intestine. If these worms are in an egg-laying stage, ova will be found in the feces. But from a practical standpoint severe cases present what seems to be a characteristic type, and even medium cases often present a more or less typical clinical history.

"The statement is not infrequently made that there is one way, and only one way, to diagnose a case of uncinariasis, namely, by examination of the stools to find the parasites or their eggs."

Sandwith[2] says: "Facies of the patient is characteristic, though it is difficult to describe his discontented, harassed expression which sometimes changes to a ready smile after a month's stay in a hospital."

Ankylostomiasis or Uncinariasis, also known as Brickmakers' and Miners' Anemia, Egyptian chlorosis, Tunnel Disease, etc., is caused by a parasite, ankylostoma duodenale (also called dochimius duodenale and uncinaria doudenale) is a cylindrical worm, female 7-16 mm. in length, the male 7-11 mm. The head is rounded and is armed with six sharp hooklike teeth.

Stengel[3] says: "The eggs are easily distinguished, being elliptical shaped, from .056 to .063 mm. in length and .036 to .04 mm. in thickness. The shell is separated from the contents, and in the state of segmentation the eggs may appear in the stools in great numbers. The embryo is fully developed outside the body, and entering the stomach and intestines of man there undergoes full development."

Smith[4] says: "The next point which concerns us is how do they reach the intestinal canal? It was not suspected until the last few years that it could reach the intestines other than through the mouth, and especially as moisture is necessary for the existence of the parasite it was supposed to gain entrance principally through drinking water. However, since Loos has demonstrated that the larvae may pass through the skin, and Bentley has attributed the pani-ghao or ground itch to the larvae, it has opened up new avenues for investigation. At first consideration of this view I was loath to believe that the parasite could gain entrance by passage through the skin, as it appeared to me more probable that it made entrance through drinking water. But after careful observation and investigation of the habits of the larvae and the disease itself as it exists, I was forced to the opinion that in the great majority of cases they gain entrance through the skin of the feet, and that the true ground itch is simply the manifestation of this passage. There is no doubt that some cases may be produced through drinking water, but my observations of the development of the larvae and the conditions surrounding the disease have led me to believe that this is the exception and not the rule. That infection could take place through dirt on the hands and then taken into the mouth, I am also inclined to believe is the exception, even more so than infection through drinking water, for it is likely that the larvae would become destroyed by drying before they would be taken into the mouth."

A majority of the observers seem to think single worms may live to be between six and seven years of age.

Examination of feces: Take a small amount, place on slip, moisten with a drop of water to spread it easily, place on the cover glass, examine with 1-4 or 1-6 objective and one-inch eye piece. Ova are easily found and can hardly be mistaken for any other form, especially if a good work on the subject is at hand.

I was materially aided in the pathologic researches by Dr. Horsfall while the patient was in the hospital, and I wish to acknowledge my appreciation of his services.

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2. Sandwith, Observation on Four Hundred Cases of Ankylostomiasis, page 13.

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SWEDENBORG'S VORTEX-RINGS AND SOME OF THEIR APPLICATIONS IN THE REALM OF NATURAL SCIENCE, WITH ESPECIAL REFERENCE TO THE SUBJECT OF THOUGHT.

By E. R. Edson, M. D.,
SEATTLE, WASH.

(Concluded.)

(3) Thought.

In the preceding chapter we considered forms of ethereal motion in the inorganic world, and I now wish to take up the subject of ethereal phenomena as they are presented in the organic world, and to investigate the nature and some of the phenomena of thought. I will state at the outset, that I employ the term thought in its broad significance, meaning "Mental activity of any kind, whether conscious or subconscious." Herbert Spencer uses the word thought similarly, as follows: "Thought, when broadly used as antithetical to things includes intuition: it comprehends in this sense all that is subjective, as distinguished from all that is objective."[6]

It is evident to all reasoning minds that thought, in order to exist or manifest itself at all, must have a material structure. If it has no material structure, is not material, then thought does not exist at all. Consequently, the only attitude which we can assume is that thought has a material basis for its existence, and that, like everything else, it is a form of motion.

Three questions now arise: (1) What is the form of this motion? (2) What medium or condition of matter does this motion exist in? (3) What are the rates of its motions?

As to question 1, What is the form of motion of thought? It is evident that a circular form is often contemplated in this connection: for instance, we often hear of "circles of thought"; again, we commonly read of "spheres of thought." But we may go one step farther and confidently assert that the currents of thought are vortical, for two reasons: (1) Thought is one of, if not the most powerful of all forces existing in Nature. We have seen that the most powerful natural forces act in the form of vortical currents. Consequently, we may reason that thought is no exception to the rule, and that its form is vortical. (2) We can see this fact displayed almost on every hand. Now let us take, as an illustration, the life or thought of some great man. About this one mind are arranged, say, 10,000 other minds, all more or less deeply engaged in the same chain of thought. Now, very close to this mind are several others, which are almost but not quite as influential as number one; they are his truly most intimate friends, though they may not be near to him physically. As we get farther away from number one, the greater becomes the number of minds on or near a certain plane of thought. But there is no break in the chain; no two minds are alike and so we find a line or chain of thought or minds, circular in form, the circles becoming broader as we go down,—i. e., nothing else than a vortex, as illustrated in the accompanying diagram. At the base are 10,000 minds which concentrate, at the vortical apex, in one mind the greatest of all.

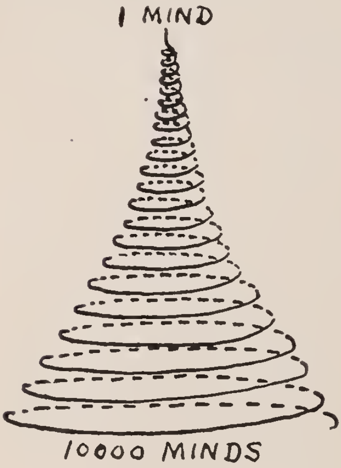

Fig. 8. A vortex of minds.

Nor is this all. We may also reason by analogy that thought, in its vortical motion, follows the perpetual type or that of the vortex-ring. Why? Because a current of thought must necessarily follow the type of other powerful natural currents such as exist in air and ether. Again, if we believe in an immortality or perpetuity of thought, we must expect thought to be perpetual in its forms of motion.

As to question 2, What medium or condition of matter is concerned in the phenomena of thought? In reply to this I will say that I believe it to be the ether. Why? For two reasons: (1) I believe that the phenomena of telepathy are similar, as regards the practical instanteity of the transference of intelligence, to those of ordinary wireless telegraphy; consequently, just as we found, earlier in this essay, that wave-motion in various media possessed definite rates in each medium, so we must conclude that, inasmuch as wave-motions of telepathy and wireless telegraphy occur at the same or nearly the same rates, the medium must be essentially the same in each case. (2) The pictures of elementary thought and also the visions of telepathy are images which appear as forms of light, even more brilliant than the light which we perceive by means of eye-sight. By means of the eyes we perceive the ether undulations of ordinary light. But in our imaginations we see clearly without the use of the eye. We see new mind-pictures which we have never seen with our eyes, and, having once seen these images or forms of light may be able to depict them on canvas if we are highly artistic. Now, as I stated, these images are seen as forms of light. We believe that light-waves are ether-waves. Consequently, the light-waves which illumine our minds are also ether-waves.

Having concluded that thought is in reality a form of perpetually-vortical ethereal motion, it remains for us to speak of the rates of its motions. As previously shown in regard to water and air, we must conclude that an analogue exists in ethereal motion and that the currents of thought flow more slowly than thought-waves are propagated through space. A wind rarely blows at a rate of over 100 miles per hour, while air-waves or sounds proceed at a rate of 700 miles per hour. Ether undulations proceed at the rate of 190,000 miles per second and telepathic undulations probably proceed with the same rapidity. However, the actual movement of ether particles from place to place, the current flow, must be much slower. Again, we must consider the rate of vibrations per second, or the number of waves which impinge upon our brains and produce these images of intellectual light. In order to comprehend this clearly, we should observe a scale or table showing the vibratory rates in various media which affect our senses. By means of touch I cannot count with accuracy, a pulse which is over 180 per minute, i. e., three per second, even with my finger on the femoral artery. By means of the sense of hearing, we appreciate alternate aerial condensations and rarefactions of rapidities varying from 16 to 40,000 per second. The Hertz waves are comparatively slow and are invisible to us. So it is with the ordinary infrared rays. By means of eyesight we can detect vibrations in the ether, ranging from 400 to 750 billions. Actinic rays undulate at the rate of 2,000 billions per second. The x-rays have a rate probably up in the trillions. It is possible that thought-waves have a vibration rate more rapid than that of the x-rays. As we progress upward in the scale of sense we can make several observations:

(1) The less dense becomes the medium through which the impression is received.

(2) The more rapid are the vibrations of that medium.

(3) The more rapid is the rate of wave-propagation.

(4) The broader becomes the circle or, the larger becomes the sphere of intelligence which is reached through the use of that medium.

The Ether, vibrations per second.

Thought		
X-Rays		Probably Trillions
Actinic Rays		2,000 Billions
The Range of Human Sight.	violet indigo blue green yellow orange red	750 billions to about 400 billions
Infra-Red		100 Billions
Hertz Waves		(approximately) 230 Millions

Air (sound), vibrations per second.

Highest audible sound	40,000
Shrill cry of bat	30,000
Highest musical note used	4,000
High soprano note	2,000
Woman's conversational voice	512 to 256
Man's voice, conversational	128
Lowest musical note used	32
Lowest audible sound	16

From "Wireless Telegraphy," by Richard Kerr, F. G. S.
(I have added "Thought" to the table.)

That is not all. We may make one more observation. The penetrating power of air is less than that of ether. We can exhaust air and make an air-vacuum, but we cannot make an ether-vacuum. In other words, ether penetrates solid bodies. Now we find. in ether, that the dark heat waves (the slow ether waves) are readily arrested and absorbed. Actinic rays penetrate soft parts, and we can photograph through the cheek. X-rays also penetrate soft parts, and bone less readily. Thought rays pass readily from one brain to another brain and, by so doing, pass through the bones of two craniums. Now, inasmuch as the penetrating power of thought waves is greater than that of x-rays, the vibratory rate must be greater as well.

We must, therefore, classify the phenomena of thought with other currents and wave-motions of the ether, that is, in the same general class as that of sunlight and sunheat, electricity and magnetism, and the question now arises, What is the source of this intellectual light? We know that ordinary light and heat emanate from the Sun. Again, the ether or electrical currents which encompass our earth and cause the phenomena of terrestrial magnetism are, I believe, caused by solar radiation. In like manner, we must conclude that the Sun is the source of our intellectual energy. There is more evidence in support of this belief, as follows: According to Swedenborg's theory of the Nebular Hypothesis,[5] the earth, as well as all the other planets, was born from the womb of the Sun, by a process of volcanic eruption, similar, in principle, to that which occurs in the equatorial regions of our own earth. If this is, as I believe it to be, true, it follows that there is nothing (aside from the material of meteors, which are relatively insignificant) on or in our earth which did not originally come from the Sun, and consequently even our very intellects had such a source. We may, therefore, say, that since intellectual energy exists on the earth, it must similarly exist on its parent the Sun, and that this Sun, which is commonly regarded as an inanimate body, is really an intellectual centre which radiates intellectual light as well as ordinary light, and that Swedenborg's doctrine in this respect was correct. If we believe this statement, we must further believe that this intellectual light has such penetrating power that it passes through the earth during the night time, for otherwise our imaginations would cease to be illumined during the period of ordinary darkness. It is not difficult to accept this statement when we consider that the ether-waves of wireless telegraphy pass through wood, or the walls of a room, unchanged, that the x-rays pass through our bodies, and that thought-rays pass through the bones of our crania.

It may be said that this intellectual light comes from the stars, that is, from the millions of other Suns in our Universe; but this is not true, because star-light is so dim, as compared with sunlight, that we must conclude that its total ether radiation, in its effect upon our earth, is very slight. Consequently, the Sun must be the source of this kind of ether radiation as well. It is the most glorious object which we behold, so brilliant that it is dazzling, even blinding, to the sight. We can better appreciate our own relative insignificance when we recollect that the volume of the Sun is 1,300,000 times, and its mass nearly 332,000 times, that of our Earth.

Granting that this intellectual light emanates from the Sun, the question now arises: How do we receive this light? It is probable that these waves are taken up by the terminal protoplasmic processes of the cells of the central nervous system, such as the pyramidal cells of the cerebral cortex, whose bases point centrally and from the sides and apices of which thread-like terminal processes emerge. Piersol[7] states that it is probable that these processes do not unite. These vibrations, which were taken up by terminal processes, can be reproduced if those processes are set into violent agitation again, and the original light-waves, i. e., original mental pictures, are reproduced. I say that these terminal protoplasmic processes are capable of reproducing the original vibrations for the following reasons: (1) In a phonograph, the cylinder merely reproduces the same air-vibrations which it received originally from the air. (2) In physics, we note Stokes' Law:[8] "A body which absorbs any particular kind of radiation will, in general, when heated, become a source of radiation of the same kind; just as a resonator will, when it vibrates, impart to the air the same kind of sound of which it may rob the air when it is relatively at rest." In a similar manner, when, by an impulse of the will, we send a message along the axis-cylinder processes of certain pyramidal cells, we cause a reproduction of the originally received vibrations of the terminal processes, and restore to the ether nothing else than that which it gave.

Having said this, the mechanism of Telepathy is a very simple matter.

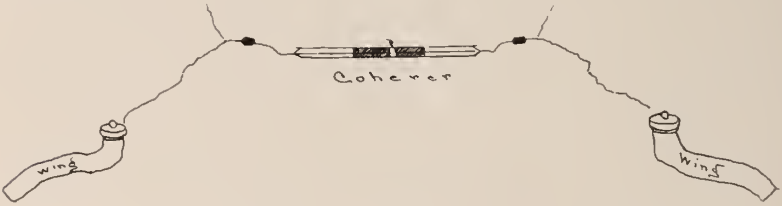

Fig. 9. A Coherer. Wireless telegraphy.

The above figure shows, roughly, a coherer, or the essential part of the receiver of a wireless telegraph instrument. In the centre is a tube containing an arrangement for delicately making and breaking the circuit in response to the ether waves sent out by the transmitter. Connected with each end of this tube is a copper strip called the "wing," whose length must be altered so that it is in syntony with or in tune with the ether waves coming through miles of space from the transmitter. The ether-waves impinge upon the wings, and, if the wings are properly attuned, they absorb the vibrations, and the circuit is closed.

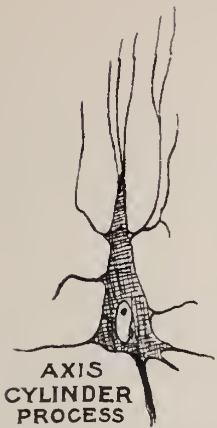

Fig. 10. Pyramidal cell from cerebral cortex. (From Clarkson's Histology.)

Here is a drawing of a pyramidal cell of the cerebral cortex; the axis-cylinder process is the wire; the terminal protoplasmic processes are the wings of this wireless telegraph instrument, i. e., the brain. We know that telepathic communications occur most vividly when thought is intense. At such times, these processes are set into violent vibration; ether-waves are radiated through space, and if another mind is in sympathy or in tune, with the mind of the transmitter, a vision is seen which is even more brilliant than the images perceived by means of ordinary sunlight, for the light-transmission, in this case, is the light of our imaginations whose images can never be fully reproduced artificially. Telepathy occurs in lesser degrees of course, almost unconsciously at times. I may also state that telepathy occurs between human beings and animals, as may be readily observed in the instance related by Ernest Seton Thompson in his book, "Wild Animals I Have Known," where he relates how his life was saved by his dog, Bingo. Animals are usually, I believe, possessed of more clairvoyant power than are human beings.

Of what practical utility is this line of thought which we have followed? It is evident to us all that we have been dealing with a powerful force, probably the most powerful of all forces of which we are cognizant, because it is capable of the greatest harmony of action or movement. Should we not learn and learn well how to use this force? To do this, we must understand it. The value of the power of thought as a therapeutic agent is very great and I believe that this value will increase with the coming years. When we make a suggestion, we induce a current or chain of thought. The origin of our lives is in thought, and we continue to exist merely because we constantly receive an influx of intellectual light and heat from the Sun. When our minds leave our bodies, the bodies decompose. The mind is supposed to live on without the body, but it is evident that our bodies cannot exist as such without the mind. In other words, the mind is the prime or essential structure. Now I believe, from the experiences of my own life, that a continuous transfer or induction of thought, or ethereal energy, can occur from one person to another over varying periods of time. I believe that I have saved life in such a manner.

The field of interplanetary communication looms up before us. It is staring us in the face today. We are communicating through space by means of ether waves in two ways, by Wireless Telegraphy and by Telepathy. Now, inasmuch as the other planets came from the same source as our earth, should we not believe that on one or more of these planets, minds must be present, either lower or higher, probably, in the scale of evolution than our own intelligences? It is reasonable to believe this. Now if such be the case, how can communication be established? By wireless telegraphy? No. Why? Because the planetary minds may not know our telegraphic code, and also may not possess telegraph instruments. But by telepathy the problem is solved. The instruments, minds, are probably there in readiness for such use; again, the images of intellectual light must be the same throughout our solar system and no telegraphic code of any kind is required, for mental images are primary. Such communication has already been attempted, and today the way is open for some person to begin such communication by telepathy and absolutely confirm communications by observing signals through powerful telescopes and also, possibly, by means of the wireless telegraph.

Before closing this article, I wish to make an earnest plea for the establishment of chairs of Psychology in all of our medical schools, by the occupants of which chairs the laws of suggestion, and the use of thought as a therapeutic agent, including a thorough demonstration of hypnosis and allied phenomena should be made clear to the young men and women who are being trained as physicians. We are confronted today by healers of many kinds outside of the medical profession. These people are doing work which should be done by the educated physicians. The general public pays them for their services. So let us lay hold of all the truth we can and send our graduates out into the world with a thorough knowledge of ethereal phenomena both in the inorganic and the organic world, so that they may be more useful servants of humanity and may, consequently, reap richer rewards.

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RHEUMATIC CHORIO-RETINITIS.*

By David DeBeck, Sc. B., M. D.
SEATTLE, WASH.

Formerly Lecturer on Ophthalmology........Medical College of Ohio;
Later, Professor of Ophthalmology.....Cincinnati Coll. Med and Surg.;
Oculist to the Cincinnati, St. Mary's and Good Samaritan Hospitals;
Life Member, Ophthalmological Society of the United Kingdom;
Late Member, American Ophthalmological Society;
Membre de la Societe Francaise d'Ophtalmologie;
Mitglied der Ophthalmologische Gesellschaft.

For some years the conviction has been growing stronger and more fixed in my mind that practically all of the inflammatory and degenerative intra-ocular diseases are complications or sequelae of general or systemic pathologic conditions. If we except the congestive and amblyopic conditions resulting from refractive and muscular defects; and set aside the well-defined group of traumatic cases, it leaves the veriest minimum of cases that may still—with any degree of warrant—be spoken of as idiopathic. And if we are to decide from past experiences, we may very safely infer that even this small group will gradually disappear as our knowledge of the ocular and systemic inter-relations becomes more perfect and precise.

A consideration of these facts will show what close associations exist between ophthalmology and general medicine ;and what close fraternal associations should exist between the ophthalmologist and the general clinician.

With these thoughts in mind, a case like the following appeals with almost equal force to either group.

Clara I.—Aet. 24. Seen in Oct., 1901. She was of robust build, but rather short; a figure that at once gave the impression as one likely to "put on flesh" in later years. Her mother had long suffered from recurrent rheumatic attacks. She herself had recently suffered from a typical attack of acute articular rheumatism in the left arm; and was still unable to resume her ordinary occupation: that of a milliner.

The right eye had become "blurred" in the last few days—during the convalescence from the systemic affection.

Vision was found to be 20|40; and the ophthalmoscope showed a mild retinitis in the zone around and above the optic nerve. This was of a soft, edematous appearance, therefore corresponding to the pathologic type of the rheumatic affections: a serous effusion. The optic nerve was involved in the serous infilation to the extent of greatly blurring it and practically obliterating its landmarks. (Fig. 1.)

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*Read before the Washington State Medical Association, Spokane, Wash., Sept. 1, 2 and 3, 1903.

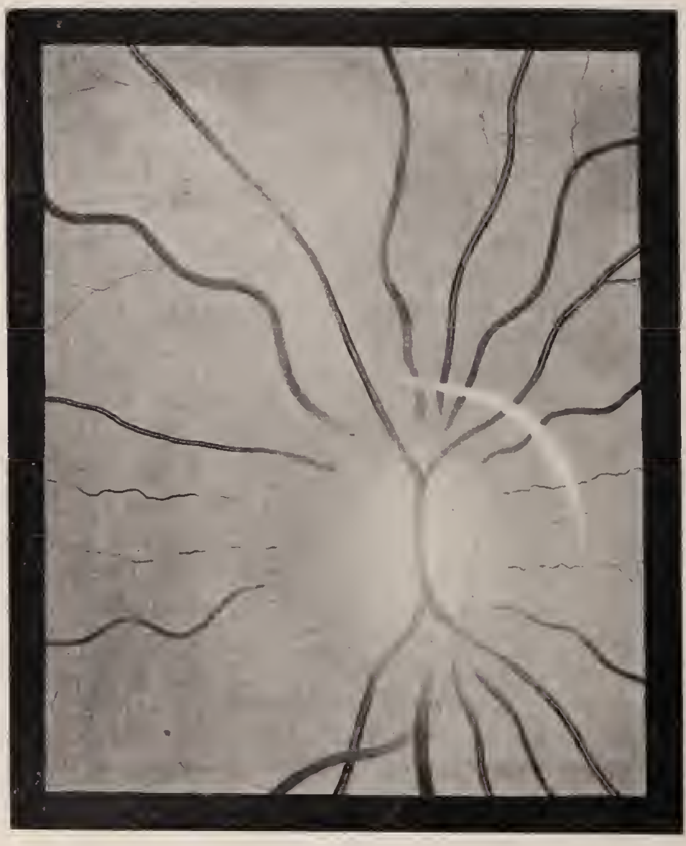

FIG. 1.

Concentric to the upper-nasal disc margin, and nearly a disc-diameter from it, was noted a narrow crescentic white streak. As this was manifestly anterior to the retinal vessels, and did not disturb them, the most probable explanation for it seemed to be to regard it as due to a slight detachment of the hyaloid membrane caused by serous effusion between this and the retina. I do not recall that this explanation has been previously advanced; in fact, I cannot find that this appearance has been previously noted—but I can conceive of no other reasonable explanation for its presence. This view is further substantiated by the fact that at a later examination this streak was found to have slightly shifted its position, and to have slightly altered in length and width. At a still later examination it had disappeared.

At an examination four days later some distinct changes were already noted. The serous effusion seemed not so marked about the disc, and the landmarks and vessels began to show through faintly. In the upper temporal field there showed a circular area of apparently deeper, i. e. chorioidal infiltration (and this it later proved to be). There was some beginning pigment massing near it; showing a commencing maceration of probably the retinal pigment layer, lying next to the chorioid. There were some faint pigment markings radiating about the disc, especially to the outer side. (Fig. 2.)

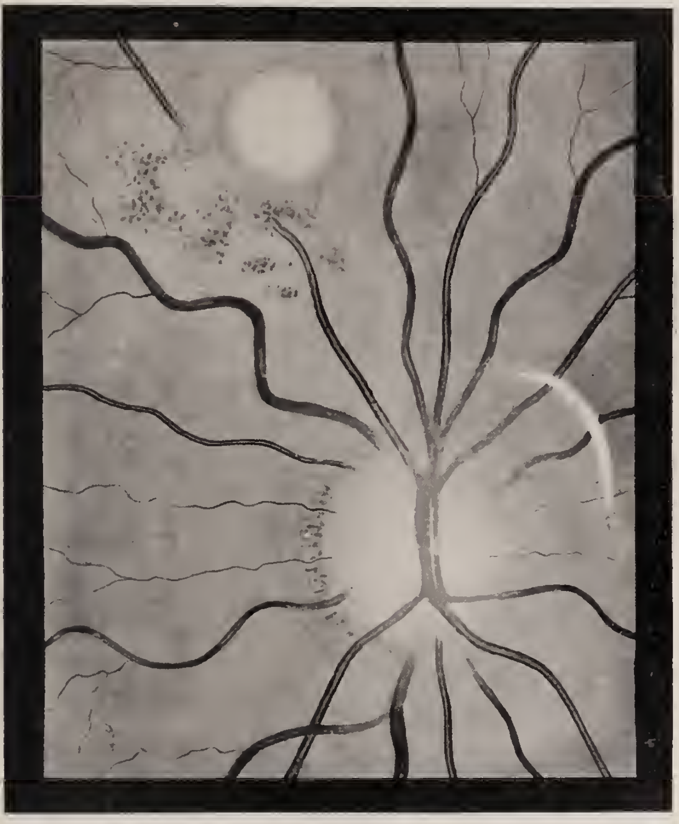

Fig. 2.

Although the edema of the fundus in general was subsiding, the effusion into the ocular end of the nerve was probably greater, for the veins were somewhat more engorged and tortuous.

Vision was still further impaired.

At the first visit she was put on the salicylate of sodium, 10 grs. three times a day. This was kept up about a week; when, as it slightly upset the stomach, it was discontinued. She was allowed to drink as much water as she desired, only that in each tumbler a 5 gr. lithia tablet was to be dissolved. Atropin was used locally, at intervals, for what effect it might have in putting the eye at rest functionally. When the sodium salicylate proved troublesome she was given lithium salicylate in the form of the granular effervescent salt, and this was borne well. After the first week the appearances changed for the better—except that the pigment massing became more pronounced. All medication was discontinued at the end of three weeks.

At an examination some months later the fundus was found practically normal, except some slight pigment striation around the disc. The round area of chorioidal infiltration showed as a round white atrophic spot ringed with pigment. The pigment massing had arranged itself into the irregular, fantastic, bone-corpuscle patches so characteristic in cases of chorio-retinitis pigmentosa; and there was some diffuse chorioidal "mottling." (Fig. 3.)

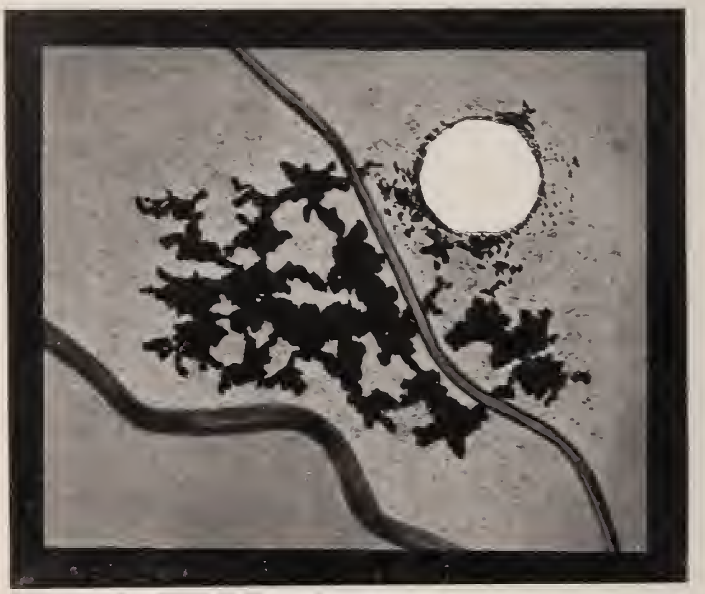

Fig. 3.

Vision was as good practically as in the other eye; so that at this visit a refractive error was corrected by giving +.75 for each eye for near work.

These cases of rheumatic chorioiditis are rare. They are almost entirely ignored by modern English and American text-books, although the "Gouty and Rheumatic Affections of the Eye" was the subject of an elaborate "symposium" at the Fourth Congress of American Physicians and Surgeons, at which Sattler read the paper on the affections of the uveal tract.

The German authors are almost equally reticent, even Knies, whose work aims to be exhaustive, while mentioning optic neuritis makes no mention of chorioiditis.

The French authors are more explicit. Renaud mentions it as a complication or sequel of rheumatic episcleritis, although it is not noted in any of the eight cases that he reports. Boquin speaks of disseminated chorioiditis, but reports no case.

Brun reports a case that is practically identical with the following case of mine. A woman, age 47, had recurrent articular rheumatism. The sight became blurred, and the ophthalmoscope showed a cloudiness of the vitreous. Under the salicylate this cleared up, and the vision became normal. There remained slight general stippling of the chorioid; while at the periphery there were patches of pigment and areas of disseminated chorioiditis.

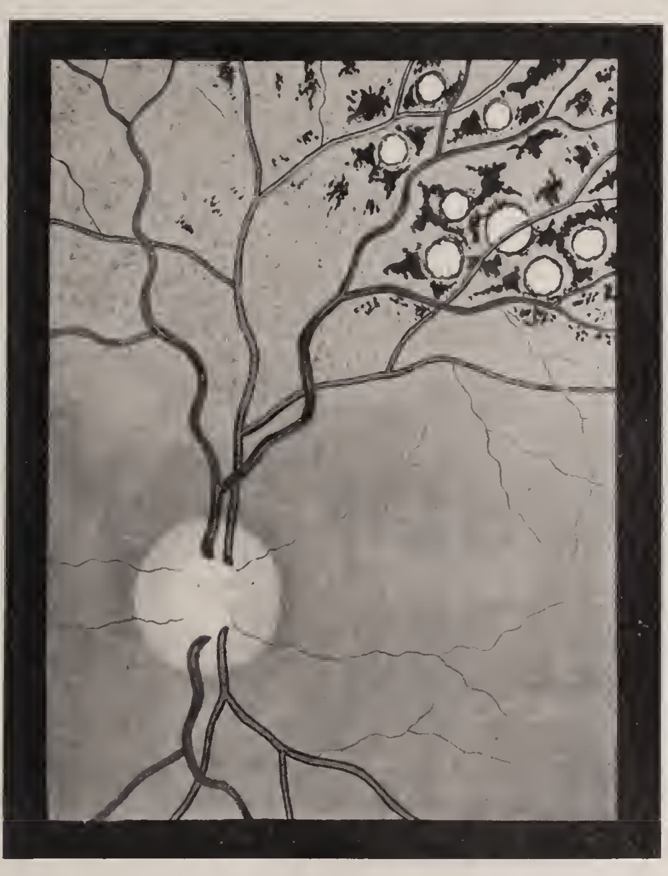

Fig. 4.

I have previously reported another case, showing the late appearances. It was in a woman of 40, who had suffered with recurrent attacks of acute articular rheumatism for several years. During and following the last attacks she suffered with episcleritis in both eyes in succession. Her blurred vision was attributed to this, and no ophthalmoscopic examination made at the time. Later the fundus was examined, and the upper segment was found to present a diffuse "mottling" of the chorioid, some scattered irregular pigment masses, and among them some round spots of chorioidal atrophy. A rather exaggerated picture of chorioiditis disseminata. (Fig. 4.)

Whether we explain rheumatism by the chemic or the microbic theory, or even if we adopt the neurotic theory of Mitchell, the final morbid result is the same. The errors of metabolism, whether they be merely the results of defective assimilation, or secondary to toxic, or even to trophic influences, result in the accumulation in the system of lactic acid or its compounds. The blood is profoundly altered and this explains the serous effusions (*but now sharply irritative*) into synovial and endothelial cavities. Thus the two other eye affections, much more frequently and certainly due to rheumatism, are an iritis, nearly always of the serous type; and the majority of cases of episcleritis, due to serous effusion into the capsule of Tenon.

With these naturally group these cases of serous neuro-retinitis and serous chorio-retinitis.

To absolutely *prove* these relations would require the finding in the secretions of the eye—for example, hypodermic aspirations from the aqueous humor or the sub-conjunctival effusion—of the same morbid agent as that found in the effusion into the joints. But this would be useless until the pathologists have agreed upon what that morbid agent really is; and even then it would be rarely practicable. So that the clinical method must content us for the present.

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CLINICAL REPORTS.

A CASE OF CHRONIC NEPHRITIS WITHOUT ALBUMIN.

By Kenelm Winslow, M. D.
SEATTLE, WASH.

The patient is of medium size and fairly well-nourished. She is one of five children, all the rest of whom are in good health. Her mother died of tuberculosis of the lungs at 40, but aside from this, her family history is excellent. The patient reports good health till ten years ago when she had an attack of inflammatory rheumatism and has been subject to some subacute attacks since. Four years ago she suffered from nausea and vomiting for several weeks which was called chronic gastritis by her physician. Four weeks prior to my first visit, she was again afflicted with nausea and vomiting which came on without apparent cause and was accompanied by some epigastric distress, but with no pain, and which lasted several days. Two weeks later when sitting in a chair one morning she became instantly and completely blind in both eyes. She did not lose consciousness but felt very weak—although she had the free use of her limbs—and therefore took to her bed for a day or two. On the following day, she could distinguish light from darkness and the sight improved so rapidly that within a few days she could read a few words, when the vision became blurred.

This was the history which was given at the first visit, some four weeks after the vomiting attack and two weeks after the advent of the blindness. At this visit the patient was about the room and complained of occasional waves of nausea, weakness, loss of appetite and blurred vision. The bowels were constipated.

A thorough physical examination was made by Dr. Geo. W. Hawley and myself. There were marked pallor and edema of the forehead, conjunctivae, eyelids and face. The pupils were equal and reacted to light and distance. There was some anesthesia of the conjunctiva but this was attributed to edema. The eye-movements were normal and there was no limitation of the visual field. The patient could read ordinary print at the usual distance. The lungs were clear. The heart's apex was situated in the fifth interspace inside the mamillary line. The outline on percussion was normal and the impulse of fair strength. A soft, systolic murmer was perceptible at the apex. The belly was negative except marked tenderness over McBurney's point. The spleen, liver and kidneys were not palpable. Ascites absent. The legs and feet were markedly edematous. The patella reflex was diminished. The superficial reflexes were absent, including Babinski's reflex, and there were no areas of anesthesia or hyperesthesia. The blood examination demonstrated normal hemoglobin-content and no change in the character or number of the cellular elements. Urinary examination revealed the following: There were 32 ounces secreted in 24 hours; pale; 1017 specific gravity; albumin and sugar absent; urea 1 per cent. The centrifuged sediment showed renal cells, a number of hyaline casts, a few granular and epithelial casts. There was some fat in the renal cells and a few droplets adhering to one epithelial cast. The stomach-contents after an Ewald test breakfast, were also examined. There was free HCl. and milk was coagulated in 10 minutes with a few drops of the filtered stomach-contents, while the coagulated white of egg was dissolved in a few hours by the same. There was absence of lactic acid, mucus and abnormal elements—in other words the result was practically a normal one.

Diagnosis. The clinical picture of gastric disturbance, waxy pallor, weakness, and edema together with the urinary findings of low urea elimination, casts and fat, forms in fact a faithful portrait of our well known enemy, Nephritis, with its usual accompaniment of albumin alone wanting to complete the verisimilitude.

And this is the point to which I wish to draw chief attention—the fact that albumin has never appeared in the urine of this patient which has been subjected to weekly examinations for perhaps six weeks. We know however that many such cases are reported and otherwise the clinical picture is true. The sudden blindness is a feature of great interest and while open to some doubt, perhaps, as to its etiology, yet I believe may be attributed to nephrotoxemia. It certainly could not have been due to any focal disturbance in the brain, as hemorrhage, embolism or thrombosis, for it is impossible to conceive of such a lesion causing total blindness in both eyes. There was no paralysis or hemianopsia. Dr. Pontius examined the eyes on three occasions, directly after the blindness and some weeks later, and he reports, as I understand it, no change at either time on opthalmoscopic examination, but at the first two examinations, anesthesia of the conjunctivae; and at the last, some limitation of the color-field in one eye, both of which suggesting to him that the blindness was due to hysteria. Both cerebral hemorrhage and hysteria have then been suggested as probable conditions in this case. Apoplexy may be readily disposed of by the history and conditions. There was complete blindness, recovering within 48 hours, no paralysis, and no loss of consciousness. The sudden blindness would suggest hemorrhage but in such a case there would be hemianopsia, instead of total blindness in both eyes. I believe that hysteria is as little credible for the age of the patient—52—with never any previous history of hysterical tendencies of any sort, but on the contrary of a calm temperament, is against it. On the other hand, we have the general symptoms and urinary examinations positively pointing with salient signs to the existence of nephritis and faulty elimination, and the production of nephotoxins, which has recently been brought so forcibly to the attention of this society by Dr. Coe, and which I believe account for the blindness and its sudden disappearance.

Treatment has been conducted along the lines laid down by Victor Vaughan, with abstinence from meat, and vegetable, cream and milk diet. The bowels were kept active, and also the skin by hot-air baths. Chlorides were withheld, after Widal and Juval, through omission of salt from the diet. The digestion and appetite are now fair, the edema is nearly, if not entirely, gone and the patient feels much better, although still rather weak and dizzy at times. One could not expect complete recovery.

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VOL. 11. MAY, 1904. NO. 5

PAPERS FOR THE WASHINGTON ASSOCIATION MEETING IN JULY.

We wish again to call attention to the annual meeting in Seattle, July 12, 13 and 14. The Committee on Program, from the general Committee of Arrangements, consists of Drs. C. A. Smith and C. W. Sharples. They desire once more to request all members of the Association who contemplate the preparation of papers, at as early a date as possible, to notify them and send the titles of the papers. While a fair number have already been promised neither the number nor variety of contributions begins to represent the abilities nor capabilities of the members. It is hoped the selection of subjects and announcements of them will not be delayed till a late date as so often occurs. The committee aims to publish a preliminary program, at a seasonable time, that will offer a fair indication of what may be anticipated at the annual session. We trust the members will appreciate the force of this presentation of the matter and act accordingly.

SHALL THE AMERICAN MEDICAL ASSOCIATION VISIT PORTLAND.

We are pleased to know that the Portland profession has worked vigorously for the meeting on 1905. While the result is still in the air our Eastern friends have been evidently impressed with the project of going West again. In order not to appear behind their neighbors to the North, the profession in Southern California came into line and have solicited the meeting for their state. We feel little uneasiness on this account. On the contrary, it will help the interests of the Northwest by calling attention more strongly to the Pacific coast. If these two sections were alone in competition for the desired meeting we would peacefully permit the question to be decided on the respective attractions of the two.

When the invitation of Portland was first presented the chief question seemed to hinge on the ability of that city to entertain the visitors. We believe this matter will be satisfactorily handled. In connection with the Lewis and Clark Fair, accommodations will be provided that will amply satisfy all demands. If the Fair were not then in contemplation the question of limited accommodations would have more force.

The objection on the score of distance seem to us Westerners somewhat of a joke. The man of maturity who has not crossed the continent and thus obtained a realizing sense of the extent and magnitude of his native land, ought to retire from practice long enough to educate himself and be able to intelligently discuss, from personal knowledge, the attractions of the richest and greatest country the Creator has presented to mankind, his own inheritance. The *Medical Sentinel* has recently depicted in glowing terms the beauties that nature has so generously bestowed on its home city and surroundings. While not wishing to detract one whit from the truths therein contained, we wish to call the attention of our Eastern visitors to the fact that Puget Sound and Alaska offer scenery, of water, mountain and forest combinations, of such magnitude and variety that the familiar and famed landscapes of the Old World are dwarfed in comparison. The Alaska trip alone is the recollection of a life time. Naturally a large proportion of the visitors will plan to return by a Northern route and inspect all that is available in the alloted time. Opportunities to this end will be provided by those familiar with local conditions and attractions.

Justice to the Pacific coast seems to demand the meeting of 1905 in the far West. We shall continue to trust and urge that the officials of the Association may select Portland for this meeting, realizing that circumstances so favorable as at the present time for holding a session in this section may not again arise.

THE SEATTLE MUNICIPAL LABORATORY.

The establishment of a municipal laboratory is one of the indications that a city appreciates the importance of carefully attending to the necessities of the public health. Seattle has become a large city before this branch of public service has been provided, although it has been the subject of discussion for some time. The city has been to a continual expense for analytical and chemical analyses of water and milk and the pressing need for systematic bacterioligic examinations has long been evident. At length the City Council awakened to a realization of the situation and appropriated the sum of $125 per month to conduct a laboratory, under the supervision of the Board of Health. Various applicants appeared for the appointment as city bacteriologist. After due consideration the work was assigned to the laboratory of the King County Medical Society, which has been permanently located in the Oriental Building, on Second Avenue. Dr. Lazelle will perform the bacteriologic work while Mr. A. G. Smith will have charge of the chemical analyses. Although this department of the Board of Health is thus in its infancy and its scope remains to be developed, it can easily be imagined that the provision for compensation and workers would be totally inadequate were the work to reach the amount attained by other cities of the size of Seattle, where this sort of laboratory has become well established. It is a source for satisfaction that a beginning has been made in this line. As the work of the laboratory developes it is anticipated that proper provision will be made for its requirements.

THE A. M. A. AT ATLANTIC CITY.

There is an assurance that the states of the Northwest will be well represented at Atlantic City next month. It is to be hoped that a large delegation may be present, both to indicate our live interest in medical affairs of national concern and as a lobby, at a possible critical moment to influence the selection of Portland for next year's meeting. We commend the latter purpose to all visitors from this interested section, knowing that no one is without some influence if it be judiciously directed. The railroads offer one fare for the round trip, from the Pacific Coast, of which details can be obtained from the agents.

MEDICAL NOTES.

Meeting of the Montana State Medical Association.—Montana will be the first state of the Northwest to hold its association meeting, which convenes at Butte, May 17 and 18. The Montana physicians always provide an interesting and profitable program. We trust a delegation may be present from the states farther West.

Idaho State Medical Examination.—The recent examination was held April 5, 6 and 7. Nineteen applicants appeared of whom nine were successful. The percentage of failures indicates that the Idaho board maintains a high standard and that a physician must be posted in medicine to practice in that state.

Chelan County Medical Society.—It is a pleasure to announce the formation of another county society in Washington. That of Chelan was organized at Leavenworth, April 1, with W. M. McCoy, of Leavenworth, president; H. A. Saunders, secretary.

TO OUR READERS AND CONTRIBUTORS.

All material for publication must be received by the first day of the month. Articles will be illustrated by half-tones or etchings when accompanied by photographs or drawings for the same. Reprints of contributed articles can be obtained at the cost of publication, from the Metropolitan Press, publishers of the journal. A limited number of additional copies of the journal will be supplied to contributors, if a request is made for them.

TO ADVERTISERS.

We wish to call attention to the fact that Northwest Medicine has no department for reading notices, publishers' notes, etc., and that reading matter and advertising pages are entirely distinct.

OBITUARY

DR. ALFRED B. KIBBE.*

By Alfred Raymond, M. D.
SEATTLE, WASH.

Dr. Alfred Beers Kibbe was born January 3, 1858, in Buffalo, New York. His father was also born in Buffalo; his mother in Little Falls, New York. Both were of English descent, whose ancestors came to America in the Mayflower. He received his early education in the public schools until fourteen years of age, when he passed on to the High School, from which he graduated at the age of eighteen. In 1877 or 1878 he entered the Buffalo Medical College, where he received his medical education, and graduated in 1889. Shortly after he went West to Denver, Colorado, and began to practice as an Occulist and Aurist in that city, where he remained for four years, when he received the appointment of Chief Surgeon of the Oregon Short Line Railroad, which required his removal to Shoshone, Idaho. He had the territory from Pocatello, Idaho, to Huntington, Oregon. He remained there until the beginning of 1899, when he removed to Seattle, where he followed the practice of Occulist and Aurist until his death.

Dr. Kibbe was one of the first physicians I met shortly after I decided to make this city my home. He was then president of the State Board of Medical Examiners, the first board appointed when the medical law came into force in this State, and from that time until his death, over thirteen years, I was more or less closely associated with him. What I shall say in this address shall be from my own observations and ideas regarding his mental qualities, pecularities of character, and his influence on the medical profession of this city, especially of this society.

Dr. Kibbe was a man of wonderful will. Whatever he undertook, whether a particular line of study, or some sport during his leisure hours, he never let up until he had reached the bottom and mastered it, and it is due to this faculty that he accomplished so much and so thoroughly. After he had completely mastered his subject, he left it and took up some other line of thought.

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*Read before the King County Medical Society, Seattle, Wash., April 18, 1904.

He had a mind of restless, ceasless activity, one that could not be shelved, that required some object for intense application all the time, which accounts for the many things that he accomplished. When his office hours were over, and the last patient had gone, he did not sit down to rest and recuperate, but instead jumped into some study which at that particular time was engaging his attention.

Shortly after I became acquainted with him, he was deeply interested in the study of psychical research. He took the journals of the Society of Psychical Research, of Great Britain. He read all the books he could get on the subject, and especially on mesmerism. He also carried out many of their experiments, and after he made up his mind that many of their statements were unreliable and unscientific, and based on false premises, he cast the whole subject aside, and I never heard him speak again upon it. About the same time he became interested in the sport of yachting, and for two or three years spent some of his leisure hours in sailing on the Sound, but I believe he took it up more for the object of learning the art of sailing than for its sport or healthy recreation. I remember hearing some members of the old Seattle Yacht Club say Dr. Kibbe was one of the best sailors on the Sound.

When the subject of bacteriology took a sudden jump from one of the most inferior positions in a physician's training to the most prominent, he plunged into the study of that science with all the ardor of his intense nature. I remember one morning, on going into his office, he showed me a culture of the bacillus coli communis, and he went on for a period of ten or fifteen minutes expatiating on its character of growth on different media, its odor its appearance under the microscope, and especially the difference between it and the typhoid bacillus. He continued the study of bacteriology during all his spare time for several months, and often it seemed he hated to see a patient come into his office, as it took him away from his microscope. He soon made up his mind to go to Berlin and enter Koch's laboratory for the further study of that subject. He traveled to that city straight as the crow flies. He did not do that which you and I would have done, namely, see the cities and countries through which we passed, and mingle pleasure with work. He remained there for several months and he told me several times that he worked in that laboratory from seven A. M. until the janitor put him out at night. Soon after his return, through the influence of his position on the State Board of Medical Examiners, he got the State to approprite several hundred dollars for the equipment of a bacteriologic laboratory in Seattle, he to be in charge of it. He went East to New York, bought the equipment and when he returned fitted up a laboratory in the Burke Building. There, with a number of the older physicians, he worked for about two and a half years; and here I wish to state that from him in that laboratory I learned practically all I know of bacteriology, pathology and histology. One by one those that started dropped out until at last only two or three were left. I finally stopped, but he continued alone for several months longer, when his health forced him to quit.

He next took up the subject of photography for the purpose of regaining his health, and any of us who remember being in his office during the next six months must recall the beautiful little specimens of the photographic art, which he had obtained in his perigrinations to the country. He seemed to take great delight in making and giving them away to his friends and patients.

I remember the evening the discovery of the X-ray was announced to the world in the daily papers. He and I had a talk about it and he immediately said, "If such is the case, what a benefit it will be to me in locating foreign bodies in the eye." A few weeks after he went to New York and in a month returned with the first X-ray apparatus in the Northwest. When he set it up he did not like the coil, so he at once made one for himself, and he told me he used five miles of wire in its construction. He made his own connections and made his magnet, which he put up in the operating room in Providence Hospital, where it remained until a few days ago. He read everything he could get on that subject, both in our own country and Europe. He made a particular study of its action on the healthy skin, and for the purpose of getting a pathologic specimen, applied it on his own elbow sufficiently long to produce a dermatitis. In a few days he cut a block of skin out of his arm, hardened, cut, stained and examined it, and sent the result in a paper to the New York Medical Journal. He was an expert in making skiagraphic plates, and was called as such in several trials for suits of malpractice against physicians in different parts of the State. He worked out a system of dosage in the treatment of skin cancer, lupus, favus, etc., but he never told me the result. In fact he was the only man in this city to my knowledge, who made a thorough scientific study of the action of the X-ray.

During the last year or two, or up to the time of his final illness, he was much interested in Japanese art. He particularly studied their superiority of coloring and their beautiful lines, especially of the old Japanese masters. He possessed the largest and finest private collection of Japanese prints in the West and probably in the country. I have related these different pursuits and studies and I believe many of the older members of this Society can attest to the fact that whatever he undertook was not done superfically, but he went to the bottom of a subject and mastered it.

His influence on the medical profession when the city was merging from a town to a city, should merit the gratitude of all the members of this Society. When so many physicians came here, shortly before and after the fire, all young men, inexperienced, unacquainted with each other, and knew next to nothing of mankind in general, it was Dr. Kibbe more than anyone else who stepped in and smoothed out the disappointments, difficulties, petty bickerings and disputes. It is due more to him than to anybody else that the harmony which began at that time still exists among all the medical men of this city. The interests of this Society was always dear to him; he was one of its steady workers and debaters, and there was not another man who could so quickly see the gist and essence of any subject which was presented, or was so completely master of speech when he had anything to say. In manner he was nervous, short, abrupt, and rather cold to strangers. He abhorred everything false. If any person ever told him an untruth he never trusted him again, but he was always true to his friends and beneath his cold exterior he had a tender nature.

Dr. Kibbe had his faults, and human nature is full of them, but his virtues so overshadowed them that those who knew him well failed to see them. Over his short comings we can easily throw the mantle of charity, and remember that which is good. His life is an example for every young professional man, who with honesty, perseverance and a well directed energy can be an honor to himself, a credit to his profession, have the respect of the community, and reap a just remuneration for his labors. That is what I call a successful life.

REPORTS OF SOCIETY MEETINGS.

KING COUNTY MEDICAL SOCIETY.

President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

The first regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce, on the evening of April 4, 1904. In the absence of the president and vice-president, the chair was occupied by H. M. Read. Thirty-three members and visitors were present.

Dr. Smith reported for the Program Committee, to which had been referred the matter of a memorial meeting to Dr. A. B. Kibbe, that it had been decided to hold such a memorial in connection with the next regular meeting of the society and that Dr. Raymond had been requested to present a sketch of Dr. Kibbe's life at that time.

The special committee on resolutions presented the following report:

Your committee appointed to draw up a resolution in regard to the death of Dr. A. B. Kibbe, beg leave to present the following for adoption by the society:

RESOLUTION.

Resolved, That through the death of Dr. Alfred Beers Kibbe, our profession has lost one of its oldest and most prominent members; that in his devotion to the highest principles of our ethics he served as a model. He was a man of indomitable will, honest in purpose, with a forceful energy, loyal and true to his friends, always respecting the rights of his fellow practitioners.

As he lived so he died, without fear and without reproach!

J. B. Eagleson,
A. Raymond,
C. W. Sharples,
Committee.

On motion of Dr. Sweeney it was voted that the resolutions be placed on file and that an engrossed copy be sent to the family of the deceased member.

PAPERS AND DISCUSSIONS.

Chronic Gastritis Simulating Cancer of Stomach.—Dr. Winslow presented the history of this patient, detailing symptoms covering several years that might apply to a number of gastric diseases. Examination of test meals gave results strongly suggesting cancer but the blood examination was normal. The doctor offered the arguments for differential diagnosis of hyperchloridia, gallstones, tabes, pancreatitis, aneurism of the aorta, ulcer, gastralgra and cancer. His final conclusion favored chronic gastritis, which was proven by improvement under appropriate treatment.

Chronic Nephritis Without Albumin.—Dr. Winslow presented the history of this case, (see page 205).

Dr. Stillson stated that Fox first called attention to contraction of the arteries of the retina in toxemia, presenting a corkscrew spiral curve. They contract and relax. This may explain the sudden and temporary blindness, also the temporary improvement of sight after the Edebohls operation. Fifteen such cases have been reported, sight having been restored soon after operation, before recovery from sclerosis could occur. He believed, in the case reported, the blindness was toxemic and not hysterical.

Dr. Pontius said the blindness was not retinal, on account of absence of usual signs, but was almost typical of hysteria. At the same time he thought it toxic. The physician who first saw her said it was not nephritic. The blindness was central and not cortical.

Dr. Greenstreet enquired whether there was abnormality of accomodation. Dr. Pontius replied it was normal after sight was restored.

Dr. Raymond first saw the patient when she had vomiting and gastric distress. He thought the sudden blindness as well as sudden recovery was hysterical. He could not understand the presence of sufficient toxemia to cause blindness with a clear cerebral condition.

Dr. Read commented on the failure to discover duodenal ulcer when stomach examination is normal. He cited an illustrative case with gastric disturbance for some time, no positive diagnosis, where operation disclosed ulcer. He thought ophthalmoscopic examination should disclose the true eye condition in the case under discussion.

In closing Dr. Winslow said the case presented positive evidence of nephritis as disclosed by examination of the urine while there was no indication of hysteria except the sudden blindness. Edema over the ankles was marked for two weeks.

A Case of Ankylostomiasis.—Dr. Thomas read the history of the case, with descriptions of the disease from several authorities (see page 187).

Dr. Horsfall, who studied the case with Dr. Thomas, described the mehtods of obtaining the parasites and ova from the feces, giving a description of each. He detailed the blood findings and differential diagnosis in chlorosis, pernicious anemia, splenic anemia and malaria.

Dr. Smith referred to the importance of diagnosis in cases of chronic diarrhea. With the present knowledge of diseases of the blood and their ready detection by proper methods, together with microscopic examination of feces, a case like that under discussion should not escape an accurate diagnostician. He deprecated the method of snap-diagnosisis and commended careful work as exhibited in the paper presented.

The second regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce, on the evening of April 18, President Heg being in the chair. Forty members and visitors were present.

Dr. Winslow exhibited a sample of urine, of specific gravity 1001, otherwise presenting nothing abnormal. He stated the patient had for a long time passed urine of this character. He discussed the causes and conditions for this character of urine.

PAPERS AND DISCUSSIONS.

Sketch of the Life of Dr. Alfred B. Kibbe.—Dr. Raymond read this paper, (see page 207). Comments on the character and incidents in the life of Dr. Kibbe were presented by Drs. Smith, Eagleson, Willis, Sharples, Russell, Sweeney, Heg and Pontius.

Cancer of Uterus, Pathology and Diagnosis—Dr. Smith delivered an address on this subject, illustrated by lantern slides, made from microphotographs, by Dr. Holmes, of pathologic specimens of the speaker. After a review of the normal histology of the cervix and endometrium, he described and illustrated the types of squamous cell carcinoma and adeno-carcinoma. In referring to diagnosis he emphasised the necessity of microscopic examinations of curettings, in case of bloody discharge after the menopause, and described the correct technic for obtaining them.

Symptomatology and Treatment.—Dr. Sharples read a paper on this subject. He dwelt on the futility of vaginal hysterectomy for cancer of the cervix, mentioning the statistics from different sources that are of the most unfavorable nature. He thought the only operation that promises a cure is the complete one, removing all available lymphatic glands, after the order of the radical operation for cancer of the breast. He discussed the more favorable outlook of operation for adeno-carcinoma of the fundus and recommended this, provided an early diagnosis were made.

Dr. Winslow remarked that, since eight or ten years should elapse before a case could be considered cured, the number of recognized cures after operation is necessaryily very small. He said Kelly does not now favor an attempt at the complete operation. He removes as much as possible of the broad ligament, recognizing that, if there is much extra-uterine involvement, there is no hope of recovery.

Dr. Read spoke of the great importance of early diagnosis of the disease. One should pay as much attention to the examination of uterine discharges as of urine for kidney disease. Then there might be a sufficient number of early operations to increase the percentage of cures. He recommended the destruction of diseased tissue by the cautery which accomplishes good and often cures.

Dr. Eagleson expressed surprise at the extent of involvment often found without apparent effect on the general health. He mentioned a case where the whole uterus, the bladder and rectum were affected and no loss of flesh evident. He referred to a local practitioner who professed to work cures by the use of a paste and described some of his cases in which large sloughs of necrotic tissue were removed, greatly to the temporary relief of the patient. He thought, in some instances, we might accomplish good by the use of these escharotics. He especially approved curetting, followed by the thermo-cautery, when hysterectomy was not advisable.

PIERCE COUNTY MEDICAL SOCIETY.

President, C. Quevli, M. D.; Secretary, A. deY. Green, M. D.

The regular meeting of the Pierce County Medical Society was held in the parlors of the Tacoma Hotel on March 29, 1904. The president, Dr. Quevli, called the meeting to order at 8:45. The minutes of the last meeting were read and adopted. Dr. R. H. Harrison was reported sick with whooping cough. Drs. John J. Sturgis, Frank A. Scott and J. H. Spencer, were elected to membership.

PAPERS.

Chronic Gastritis.—Drs. R. H. Brown and Wm. McCreery spoke on Etiology and Pathology; Dr. Perkins on Symptoms and Diagonsis; Treatment, Dr. Coleman.

Meeting adjourned at 11 p. m.

On April 19, 1904, the regular meeting of the Pierce County Medical Society was held in the parlors of the Tacoma Hotel. Those present were: Drs. Yocom, M. C. L. Balabanoff, Annie Reynolds, E. M. Brown, Moore, Hill, Warren Brown, Kehoe, Alice Smith, Lowell, Gove, Coleman, Dewey, Bean, Allan, Regli, Sargentich, Douglas, Walker, VanVetchen, McGeer, Case and Quevli.

A communication was read from Dr. Carl Hoffman explaining the new laboratory of the King County Medical Society.

PROGRAM.

Dr. E. M. Brown discussed Ulcer of the Stomach; Dr. C. E. Case, Cancer of the Stomach.

On account of the late hour, Dr. Yocom moved that the rest of the program be concluded at the next meeting.

Dr. Case requested the president to invite Dr. E. M. Brown to deliver a lecture on Gun Shot Wounds of the Abdomen and Intestinal Perforations. Dr. Brown accepted the invitation and promised to devote the entire evening on May 17th, to that subject.

WHATCOM COUNTY MEDICAL SOCIETY.

President D. E. Briggs, M. D.; Secretary, W. H. Hunt, M. D.

The Whatcom Coupnty Medical Society met in regular monthly session April 11, 1904, in the library room of the Odd Fellows building, Bellingham, Wash. In the absence of President Biggs, Dr. C. L. Holt occupied the chair.

The committee, appointed at the last meeting to confer with the sanitation committee of the charter commission, reported that they had made a number of suggestions to the latter committee, most of which had been acceped and would be incorporated in the new charter.

The application of Dr. A. T. Kaupp for membership in the society was received and referred to the committee on admission and ethics.

PAPERS AND DISCUSSIONS.

Surgical Gynecology.—The paper of the evening was read by Dr. L. R. Markley, on the subject of Surgical Gynecology. The doctor deplored the tendency in recent years to use the knife too freely but thought the pendulum was now swinging in the direction of greater conservatism in gynecologic work. He then considered in detail the conditions in which surgical means are necessary, or preferable, to medical treatment.

The paper was discussed by Drs. Holt, Kirkpatrick, Boynton, Smith and Hunt.

Adjourned to meet May 9, 1904.

BOOK REVIEWS.

Edited by

Kenelm Winslow, M. D.

The Care of the Baby. A Manual for Mothers and Nurses, containing practical directions for the management of infancy and childhood in health and disease. By J. P. Crozer Griffith, M. D., Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania, etc. Third edition, thoroughly revised. 436 pp. Illustrated, W. B. Saunders & Co., Phila., New York, London. $1.50.

This is the most thorough and complete of the innumerable "baby books" which have recently been offered to the public. The object of the book is stated to be—to make the mother understand what she can do without medical advice, and how she shall do it; when she shall call a physician to her aid, and what she shall do before he comes. It is intended especially for mothers living far removed from a physician. The work begins with a description of the hygiene of pregnancy and preparations for pregnancy, and then proceeds to the characteristics of the healthy baby. It might have been well to have added a section on the management of childbirth in the absence of a physician, but if any fault is to be found with the book as a whole it is that there is too much in it for the average mother to grasp—as for instance the directions for analysis of the breast-milk by the mother, by determination of the fat-content and specific gravity with the assistance of appended tables. The human brain is somewhat like a milk pail and if it is suddenly overfilled the contents will spill over and some of the richest portion may be lost. The description of the care of the baby is minute and clearly put and appropriately illustrated, but not—fortunately—to the absurd degree which is seen in some of the newer "baby books" in one of which may be found an elaborate cut, life-size, of baby's Pap-Spoon beautifully embossed and containing in the bowl an allegorical picture entitled "Hey' diddle, diddle" with the classical dog, dish, and cat-with-the-fiddle and the cow in the process of her famous salutatory, supra-lunar feat. This is no medicine, it is consummate bosh.

In the matter of artificial feeding the book will prove a disappointment to the mother as the author, while describing fully the theory, disapproves of the parent endeavoring to feed her baby without professional advice and therefore gives no specific directions for doing it. In this he differs from Holt and others, and, while he is undoubtedly right as regards those mothers who can readily procure medical advice, the book loses thereby much of its value for the mother living in remote parts for whom the author believes the work will be of most worth. The chemistry, preparation, sterilization, and all the other details concerning milk are most minutely detailed. The chapters upon feeding the baby in the later periods, and on sleep, on exercise and training, and on baby's nurses and rooms, are admirable; 143 pages are devoted to the "sick baby". The general features of disease and management of the sick infant receive great care; all the common paraphenalia of the sick-room—atomizers, syringes, graduates, the thermometer, etc—are described as well as their mode of use. All the more common disorders, injuries and accidents of childhood are enumerated, with their symptoms and treatment, in the most practical style. The appendix is particularly valuable for its dietary list and formulae for medicinal preparations, doses and drugs, and all kinds of useful information. The mother who masters the contents of the book could pass most examinations in children's diseases in our medical schools—barring much pathology. It is the most complete medical text book on childrens' diseases for the laiety extant and, notwithstanding, is irreproachable from an ethical standpoint. WINSLOW.

International Medical Annual, 1904, Twenty-second year; 742 pages. Illustrated by 34 photographic plates and 38 diagrams. E. B. Treat & Co., New York; $3.00.

This familiar publication grows with the passing years both in size and richness but still manages to keep its compact and handy form notwithstanding the corpulence which its mature age justifies. Stockton, in the review of recent therapeutics, notices no new addition of much value within the past year but records the passing of spinal anesthesia, the cacodylates as substitutes for arsenic, and the intravenous use of gelatin for arresting hemorrhage (fortunately before the average practitioner had come to the point of employing either of them). On the other hand adrenalin is constantly growing in appreciation, especially when combined with cocain as a hemostatic, and in prolonging the action of cocain. A mode of administering ether in drop doses, together with the subcutaneous use of a small dose of morphin, is described as an improvement in avoiding after-nausea and lung-complications, and in ensuring absolute safety during inhalation. An ordinary chloroform mask is employed. Radio-activity receives ample attention both in the use of the X-ray and with radium. One finds considerable space given to the intravenous administration of remedies which used to be considered attended with danger on account of the sudden effect of drugs when given in this manner, and the possibility of the entrance of air into the veins. (Fear of the latter contingency is doubtless ungrounded—except in rare instances—as when students we experimented by blowing air through a large blowpipe into the external juglar of a horse and notwithstanding that several of us tried a hand and exhausted strength in this lung-testing work, the horse was not in any way inconvenienced thereby.) Intravenous medication seems indeed to be now quite the vogue. There are some novelties in the way of illustration in the form of stereograms or stereoscopic views of the bony structures of the region about the ear. These plates are beautifully clear and give one the impression—which is the characteristic of steroscopes—of a solid body rather than a flat drawing, and are intended to be of service for those doing the mastoid operation. There are also most excellent plates of some of the infectious disorders. Time does not permit of an extended review of a book which is of itself a review of the medical literature of the past year. Suffice it to say that there is no work of the kind which contains so much in so compact a form for such a modest price.

WINSLOW.

REPORT OF CONTAGIOUS DISEASES.

To the Washington State Board of Health for March, 1904.

Counties.	Smallpox		Scarlet Fever		Diphtheria		Typhoid Fever	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Adams	1	0	2	0	3	0	0	0
Asotin	0	0	0	0	20	0	2	0
Chehalis	0	0	3	1	1	0	0	1
Chelan	4	0	2	0	0	0	0	0
Clallam	1	0	0	0	0	0	0	0
Columbia	0	0	1	0	0	0	0	0
Cowlitz	0	0	0	0	0	0	2	0
Douglas	0	0	3	1	0	0	0	0
Franklin	1	0	0	0	0	0	0	0
King	7	0	15	2	18	2	1	0
Kitsap	0	0	1	0	8	1	0	0
Klickitat	3	0	0	0	0	0	0	0
Liwis	0	0	2	0	0	0	1	0
Lincoln	0	0	0	0	3	1	7	0
Mason	1	0	4	0	1	0	0	0
Pacific	0	0	2	0	0	0	0	0
Pierce	0	0	0	0	1	0	0	0
Skagit	0	0	0	0	1	0	0	0
Spokane	0	0	2	0	0	0	0	0
Thurston	0	0	3	1	0	0	0	0
Wahkiakum	0	0	0	0	0	0	1	0
Walla Walla	0	0	1	0	2	0	1	0
Whatcom	0	0	2	1	0	0	0	0
Whitman	1	0	3	0	1	0	3	0
Yakima	1	0	0	0	0	0	2	0
Seattle (city)	15	0	73	3	28	3	12	3
Spokane (city)	4	0	2	0	7	0	2	3
Tacoma (city)	1	0	2	1	2	0	2	2
Total	40	0	123	10	96	9	35	9
Total, Mar., 1903	78	0	89	0	16	0		
Total, 1904	132	1	434	20	298	38	165	38
Total same period 1903	269	0	217	0	46	0		

ELMER E. HEG, Secretary.

MEDICAL SOCIETIES.

Name. Meetings Held.

Washington State Medical Association.........July 12, 13, 14—Seattle
President, F. H. Coe, M. D.; Secretary, A. H. Coe, M. D.

Chehalis County Society ....Second Tuesday—Aberdeen
President, D. A. Schumacher, M. D.; Secretary, J. W. Scamell, M. D.

Chelan County Medical Society...............................
President, W. M. McCoy, M. D.; Secretary, H. A. Saunders, M. D.

King County Society ....First and Third Monday—Seattle
President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

Pacific County Society ....
............Third Monday of Jan., April, July, Oct.—South Bend
President, G. W. Overmeyer, M. D.; Secretary, Mary W. Gunwell, M. D.

Pierce County Society............First and Third Tuesday—Tacoma
President, C. Quevli, M. D., Secretary, A. de Y. Green, M. D.

Skagit County Society ....
President, A. C. Lewis, M. D.; Secretary, R. J. Cassel, M. D.

Snohomish County Society..................First Tuesday—Everett
President, C. A. Mead, M. D.; Secretary, James Chisholm, M. D.

Spokane County Society...................First Thursday—Spokane
President, G. S. Armstrong, M. D.; Secretary, Geo. A. Gray, M. D.

Walla Walla County Society.........Second Wednesday—Walla Walla
President, N. G. Blalock, M. D.; Secretary, Y. C. Blalock, M. D.

Whatcom County Society.................Second Monday—Whatcom
President, D. E. Biggs, M. D.; Secretary, W. N. Hunt, M. D.

Whitman County Socity.........Third Monday of Jan., Apr., July, Oct.
President, W. N. Divine, M. D.; Secretary, R. J. Skaife.

Yakima County Society.............First Tuesday—North Yakima
President, David Rosser, M. D.; Secretary, Carver, M. D.

Oregon State Medical Association.....................1904—Portland
President, W. T. Williamson, M. D.; Secretary, L. H. Hamilton, M. D.

City and County Medical Society of Portland...First Wed.—Portland
President, R. L. Gillespie, M. D.; Secretary, A. D. Mackenzie, M. D.

Multnomah County Medical Society..........First Tuesday—Portland
President, A. Tilzer, M. D.; Secretary, L. Victoria Hampton, M. D.

Montana State Medical Association...........May 17 and 18—Butte
President, L. Bernheim, M. D.; Secretary, B. C. Brooke, M. D.

Silver Bow Medical Society....Second and Fourth Wednesdays—Butte
President, T. J. Murray, M. D.; Secretary, Grace W. Cahoon, M. D.

Idaho State Medical Association...........October 6 and 7—Lewiston
President, J. L. Conant, Jr.; Secretary, E. E. Maxey, M. D.

Northern Idaho District Medical Society............June 9—Lewiston
President, C. L. Gritman, M. D.; Secretary, C. D. Parsons, M. D.

Southern Idaho District Medical Society...............April 7—Boise
President, W. E. Hargrave, M. D.; Secretary, H. A. Castle, M. D.

Canadian Medical Association...........Aug. 23, 24, 25—Vancouver

British Columbia Medical Association..............1904—Vancouver
President, A. P. Procter, M. D.; Secretary, W. D. Brydone-Jack, M. D.

Vancouver Medical Society ....Vancouver
President, W. D. Brydone-Jack, M. D.; Secretary, J. S. Conklin, M. D.

Corrections and additions to this list are requested from societies reached by this journal.

NORTHWEST MEDICINE

June, 1904.

ORIGINAL CONTRIBUTIONS.

DETAILS OF A SCHEME FOR SUBJECTIVE MEASUREMENT OF THE PUPIL OF THE EYE.

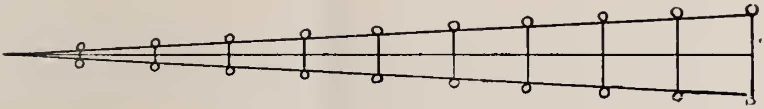
By Clinton T. Cooke, M. D.,

SEATTLE, WASH.

Of the various schemes for measuring the pupil by objective methods, the one described and figured by De Schwenitz (Am. Text Book Eye, Ear, Nose and Throat) is probably as widely used and as free from error as any except the millimeter scale held in front of the eye and the apparent width of the pupil read off directly. The manifest impossibility of making accurate measurement by this method, together with the desirability of being able to estimate or measure accurately the excursions of the iris has led to the experiments and measurements on which this paper is based.

EXPERIMENT I.

Taking an ordinary visiting card and a pin, two series of stenopeic openings are to be made at equal intervals along two diverging lines intersecting at one end, at the other being 10 mm. apart. Thus:



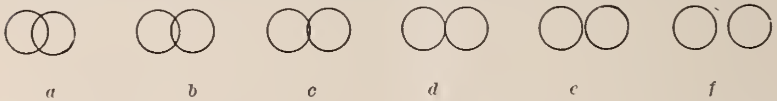
(These openings can be enlarged to a given size by a Theobald lachrymal probe.)

If this card be now held before a normal emmetropic eye, accommodated for distance, at an approximate distance of 13 mm., as in Scheiner's experiment, and the gaze be directed at some distant illuminated object as, for example, the sky, through these pairs of openings, the size of the field of vision will depend upon three chief variable factors: (*a*) The size of the openings in the card. (*b*) The size of the pupil. (*c*) The distance between the openings. The distance of the card from the cornea may also enter into the case, but inasmuch as a few millimeters either way does not alter the measurements of the pupil by more than a few hundredths of a millimeter, and as 13 mm. is a distance easily estimated or measured, further reference to this factor is omitted, (See on this point Tscherning Phys. Optics, p. 84, Principle of Badal.)

(*a*) The size of the openings may be controlled easily. An *opening* 1 mm. in diameter, at 13.7 mm. from the cornea, forms an angle of about 4° with a point on the cornea. An opening of 4 mm. at the same distance forms an angle of about 16°. With a pupil 3 mm. in diameter, a *field* which has an angle of over 16° is visible through a 1 mm. opening, and an angle of over 20° when seen through a 4 mm. opening. (The aperature of the eye is 20° with a 4 mm. pupil, and a larger field being visible when the pupil is dilated.)

(*b*) The size of the pupil varying according to well-known conditions contracting to light, accommodation and convergence, is the chief variable factor in determining the size of the field seen through a small opening and because its measurement is accomplished by means of (*c*) the third variable factor, we will consider them together.

First, then, looking through the first pair of openings in the card, two circular fields will be seen whose margins overlap. The segments included by the overlap allowing twice as much light to reach the retina seem brighter and better illuminated than the remainder of the circle, thus: (*a*). The next pair will overlap less, thus: (*b*). The third pair still less (*c*). Presently a pair will be seen whose margins are tangent to each other, thus: (*d*). The next pair are separated (*e*), and the next are separated more yet: (*f*). Now the pair of fields whose margins are just tangent to each other is seen through two stenopeic openings which are separated by opaque cardboard, and the width of cardboard between these two steneopic openings is very nearly an exact measure of the size of the pupil. To prove this, and to calculate the error which arises from the refraction by the cornea and aqueous humor, is the object of this paper. The following diagrams



show the course of the light rays, and if correct are proof of the correctness of the assertion just made. The calculation of the error follows.

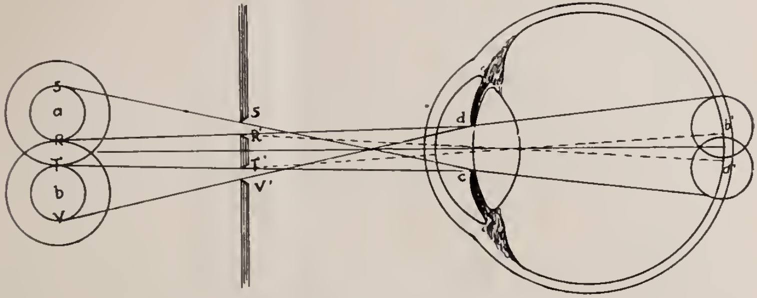


Diagram 1.

In this diagram, which resembles Brewster's for determination of position of entoptic objects, the location of the screen being at the anterior focal point of the eye, the ray Rd may be considered as emanating from R^1. This ray, after refraction, will run parallel to the nodal ray coming from the point R^1. A similar construction determines the course of the ray SS^1, likewise the course of the rays from T and V. It will be seen that no ray coming from a point higher than S or lower than R can enter the eye through the upper opening in the screen, hence with this screen the size of the field visible externally is limited by the size of the pupil. A similar remark applies to the rays TT^1 and VV^1 and the lower opening in the screen.

Light emanating from the portion of the circles *a* and *b* projected which lies between the points T and R strikes the retina

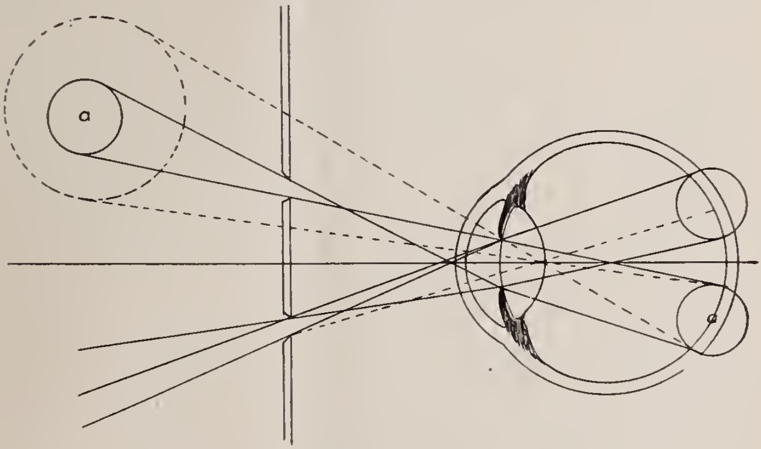


Diagram 2.

between the points a¹ and b¹, thus doubling the amount of light received. Therefore, the stimulus to the rods and cones being greater, we seem to see objects between T and R in a brighter light. It will be observed the distance between the openings in the screen is less than the diameter of the pupil.

In diagram 2 the openings in the screen are separated by a distance greater than the diameter of the pupil. Projection outwards being through the nodal points, the adjacent margins of the fields of vision appear to be separated. The essential point, however, is that no ray of light parallel to the principal axis of the eye can reach the fovea, whereas in the conditions shown by diagram 1 this is possible. If in a diagram similar to this one in other respects the openings in the screen were indefinitely enlarged, while the inner margins were still separated by a distance greater than the diameter of the pupil, it would remain true that rays parallel to the principal axis could not reach the fovea.

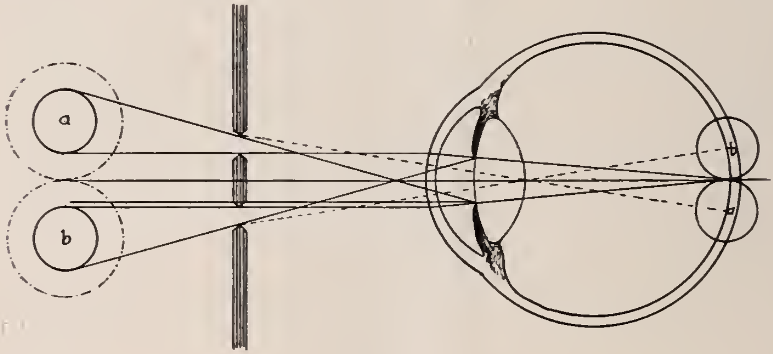


Diagram 3.

In diagram 3, however, the circles *a* and *b* would appear to be tangent to one another because the margins of their images are in contact at the fovea, and this because the eye is by hypothesis normal and emmetropic. In such an eye rays parallel to the principal axis are focused on the fovea and, as remarked before, the projection outward of the image of this inner margin of these fields is through the nodal point. This is further shown by looking through a pair of openings, whose images overlap, at a fixed star, or at an electric light at a distance of, say, 100 meters, when it will appear single and at the point of fixation if the eye is emmetropic, or properly corrected, unless the openings are so small and near together as to cause the familiar lines due to interference. If the margins of the fields do not overlap the star can be seen through only one circle at a time. (Scheiner's Experiment.)

In diagrams 1 and 2 no account has been taken of the refraction caused by the cornea and aqueous. This refraction necessitates a different construction and calculation for each stated diameter of the pupil.

The diffusion circles in ametropia must also be taken into account. For the present, the calculation of the distance between two openings in a card whose subtending visual fields appear to be tangent with a pupil of, say, 8 mm. will suffice. In this calculation it is necessary to be rather exact, because it is easy to measure with 0.25 mm. of the *true* size of the pupil. It will be necessary first to calculate the distance between the plane of the anterior surface of the cornea and the plane of the pupil.

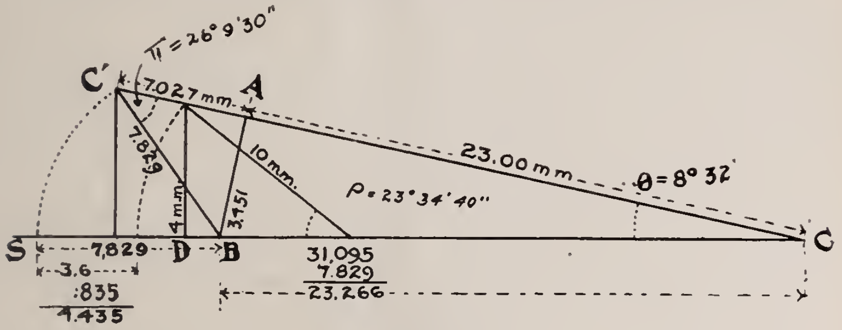


DIAGRAM 4.

This distance is 3.6 mm. plus the versed sine of an arc whose chord is 8 mm. and whose radius is 10 mm. (These constants are after Landolt.) Half the angle ρ is 23° 34′ 40″, and the versed sine is 0.835 mm. $3.6+.835=4.435$ mm.

With an index of refraction of 1.3365 the second focal distance of the anterior surface of the normal cornea is 31.095 mm. The angle whose sine is 4 mm. and whose cosine is 31.095—4.435 mm. (or 26.660) is 8° 32′, which gives us the course of the ray parallel to the principal axis, that is just able to clear the pupillary margin of the iris. We now need to know the point on the corneal surface which this ray must intersect. This point is found as follows:

Knowing the angle θ 8° 32′ and the side BC, we may regard the latter as the hypotenuse and find the line AB by the formula, $c=\frac{a \text{ sine } C}{r}$, in which a equals the line BC, c equals the line AB and C equals angle 8° 32′. Applying Logarithms this formula reads: Log. a+Log. sine of C—10=Log. c.

Log. a (23.266) 1.366610
Log. sine C. (8° 32′) 9.171389
10.537999—10=.537999=c=3.451 mm.

Applying to these quantities the trigonometrical formula, $b = -\frac{a \cos. C}{r}-$ we find the length of the line AC (*b*) to be Log. a+Log. cos. C—10=Log. b.

Log. a 1.366610
Log. cos. C 9.995146
11.361756—10=1.361756=b=23.00 mm.

The line AC is found by first computing the angle BC^1 A (π) which we find to be 26° 9′ 30″, and, applying the same formula as before, we find the cosine of 26° 9′ 30″ with radius 7.829 to be 7.027 mm. This last added to the sum 23.00 mm. gives the length of the line CC^1, 30.027 mm., which is to say at an angle of 8° 32′ from the second focus of the anterior surface of the cornea, in order to clear the pupillary margin, the ray of light must cut the cornea at a point distant from the principal axis equal to the sine of 8° 32′ with a radius of 30.027 mm. This sine is found by the above formula (Log. a+Log. sine C—10=Log. c) to be 4.455 mm. (4.455×2=8.910). This is the distance which should separate the stenopeic openings in order to give two fields whose margins appear exactly tangent with a pupil of 8 mm. With a radius of curvature of the cornea equal to 8 mm. the corresponding result 4.450×2=8.90 mm.: with a corneal radius of 7.5 mm. the corresponding result is 4.53×2=9.06; and with the same radius the correction for a 4 mm. pupil is 2.266×2=4.532.

A method of calculation which gives nearly the same result is that which is used to calculate the position of the apparent pupil, making use of the general formula—(after Tscherning): $\frac{F^1}{f1}+\frac{F^2}{f2}=1$, in which $F^1=24$, $F^2=32$, $f^1=3.04$, $f^2=3.6$ and if $\frac{I}{0}=\frac{F^2}{I^2}$, $0=4$ mm. $I^2=3.6-32$ mm. $=$ -28.4 mm. $I= \frac{4 \times 32}{28.4} =$ 4.5 mm.

Using this formula, the corrections are:

For an	8	mm.	pupil	9.01	mm.
	7	"	"	7.88	"
	6	"	"	6.76	"
	5	"	"	5.6	"
	4	"	"	4.507	"
	3	"	"	3.3	"
	2	"	"	2.2	"

Spherical aberration of the cornea may influence the measurement, but inasmuch as the greatest degree of aberration found by Brudzewski was only +4.5D, and because ametropia or accommodation of 5D or less only influences the result in the second decimal place the results would seem sufficiently accurate without correction for spherical aberration of the cornea.

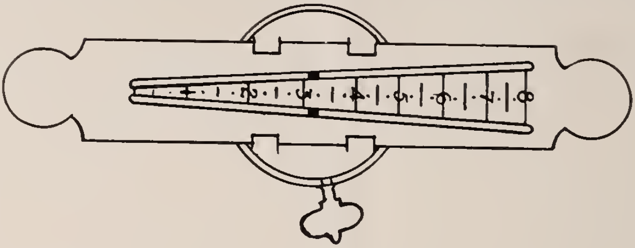
The observation that the average excursion of the iris during accommodation is about 0.50 mm. should not be greatly misleading. This amount is, however, subject to more or less correction. The apparent size of the crystalline image of the pupil of course alters with the change of radius of its anterior surface being, according to Tscherning, 0.2 mm. larger than the real pupil in the eye at rest. The error from this source does not require a correction greater than the second decimal place. It makes the apparent excursion of the iris in accommodation measure greater than the real excursion.

When the pupil exceeds 7 mm. account may be taken of the spherical aberration of the crystalline. Stadfeldt has shown that in the vast majority of lenses aberration is slight to a point 3.5 mm. from the axis.

These considerations seem to show that absolute accuracy by any such scheme is not attainable. Moreover, diffraction causes the edge of the fields to be anything but sharply defined. Furthermore, the retinal image of the distant fields being real, inverted and sharply defined cannot be made to coincide with the crystalline image of the real pupil, which is virtual, erect, and so far as the rods and cones are concerned, diffuse. Nevertheless the point where it is possible to say the fields do not touch and the point where it is certain they overlap are only about 0.25 mm. apart. The method appears, therefore, sufficiently accurate for clinical use.

EXPERIMENT 2.

Determine the pair of stenopeic openings whose margins appear to be tangent to each other when the screen is placed before the right eye, the left eye being closed meanwhile. If the left eye be now opened and a moderate amount of light be allowed to enter it, the circles seen with the right eye will appear to draw apart and it will be necessary to select a pair whose margins are nearer together in order that the circles may appear to be tangent. This phenomenon is due to the consensual contraction of the right iris. The contraction will be found to be somewhere about 1 mm. in a normal eye in ordinary diffuse daylight. Upon alternately closing and opening the left eye the excursions of the iris of the right eye may be watched. The contraction or dilatation seems to be greater than is required and a slight adjustment occurs which corresponds exactly in point of time with the to and fro movement of the iris of the left eye if it is watched by another observer.



AUTHOR'S KOREMETER.

In order to apply and make practical these observations and calculations, I use an instrument which might appropriately be termed a koremeter. As it is impossible to punch or drill openings in a metal disc so that the distances between them should be exact. use is made of a narrow strip of metal which tapers from ten to one mm. in width, resembling somewhat one of the rules of Young's Optometer. It is easy to graduate to 1-10 mm. Using such a strip of metal across the ordinary stenopeic slit of the test case. with a device to hold it before the center of the slit. one can easily and quickly measure the pupil. As to accuracy, it is possible. even with patients of a very low order of intelligence, to measure the excursion of the iris in contraction to light. Measurement of the excursion with accommodation is more difficult, but averages about 0.50 mm.

The corrected scale as computed, according to the foregoing formula, is accurate enough for ordinary purposes. Four millimeters on the scale corresponds to that size of pupil in the emmetropic eye. The actual distance across the metal at that point is 4.44 mm. For 8 mm. the corresponding distance is 8.91.

The correction for curvature ametropia is only 0.01 mm. for a pupil of 8 mm. with radius of curvature of 8.00; and 0.09 for 4 mm. pupil, with corneal radius 7.50 mm.

THE TREATMENT OF ACUTE, ANTERIOR GONORRHEA IN THE MALE, FROM A HYGIENIC, ASEPTIC AND ANTISEPTIC POINT OF VIEW.*

By G. S. Peterkin, M. D.

SEATTLE, WASH.

Acute, anterior gonorrhea I shall define as an acute infectious disease caused by a specific micro-organism, the gonococcus of Neisser; invading the mucous membrane of the urethra, it causes an inflammation of the canal, that is amenable to surgical treatment. The invading micro-organism, the gonococcus, as has been demonstrated by Finger and Achlagenhanfer, thirty-six hours after inoculation, commences to penetrate between the epithelial cells and causes congestion of the blood vessels, hypersecretion of glandular tissue, diapedesis (exudation of the elements of the blood). phagocytosis and production of embryonic cells.

The above phenomena, common to all inflammation, are possessed of a peculiar and distinctive significance in this disease, when viewed from a therapeutic point of view, in so much as they occur in a member of the body whose physiologic and anatomic characteristics render the methods of applying the ordinary local principles of surgical treatment very difficult, if not almost impossible, for physical rest cannot be given to this inflamed area, since it is located in the penis, whose functions do not permit of absolute quietness. Neither can the inflamed area be kept free from mechanical and chemical irritation, as it is upon the surface of a canal, through which passes an acid excretion of the body. Likewise it cannot be kept surgically clean, for the form and configuration of the urethral canal is such that the discharge prevents free drainage and an ocular view of the inflamed surface. Moreover, the inflamed area is so inaccessibly situated upon a delicate mucous membrane, that the local application of medicine to the inflamed area alone is impossible as the medicine must at the same time come in contact with the surrounding tissues. This being true, the use of the severe antiseptics necessary to the destruction of the specific infection, the gonococci, cannot be employed without causing greater damage to the surrounding membrane than would compensate for the benefit derived from the death of the bacteria.

It is these physical and physiologic factors that prevent the physician of today from attaining results equal to our present state of knowledge, rather than the specificity of the invading micro-organism, of whose biologic life or power we know nothing, except that it is infectious and the specific germ of the disease, factors of material importance in the prevention rather than the cure of gonorrhea.

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*Read before the Washington State Medical Association, Spokane, Wash., September 1, 2 and 3, 1903.

Accepting the above anatomic, physiologic and pathologic conditions as practical philosophic facts, this therapeutic problem then confronts the surgeon, to adopt the least expensive, simplest, and yet most efficient methods of obtaining the object demanded by the recognized principles of aseptic and antiseptic surgery in disease; the eradication of the exciting cause of the disease, bacteria, with the least possible injury and detriment to the animal organism. The method of direct local application of medicine alone to the diseased area will not suffice to cure acute gonorrhea, for reasons previously stated. It becomes encumbent, therefore, to resort for aid to the only remaining means at hand, the indirect method, the aiding of the animal economy in its physiologic attempt to overcome the existing pathologic process.

In this endeavor to assist the body in resisting the invading organism all means of so doing must be employed by the physician, if not antagonistic. And even the most trivial cannot be conscientiously omitted, since we cannot determine its relative value as a therapeutic means in any individual case. since the state of knowledge has not yet been attained where it is possible to determine the relative power of infection or resistance to destruction of this micro-organism at any one time or in any one case. Likewise the susceptibility for resisting infection of an individual is also an unknown and uncontrolable quantity.

In a resume of this preamble, let us picture the common sense position the practical physician will find himself in, as regards treatment, after an unbiased. philosophic and rational review of the knowledge he possesses regarding this disease: First, he is unable to employ the usual direct means and methods in the treatment of a local surgical infection, because of the anatomic and physiologic characteristics of the urethra and penis. Second, he does not possess a practical knowledge of the biologic life of the gonococcus or the forces that govern it. Even a practical knowledge of the forces and environments that increase or diminish an individual's susceptibility to the infection is an unknown quantity. But he does know that the exciting cause to be eradicated and the inflammatory processes accompanying it,—congestion of the blood vessels, hypersecretion of grandular tissue, diapedesis, phagocytosis and production of embryonic cells—is nature's attempt to destroy the infecting microbe and repair the damage it causes.

Thus we must recognize in gonorrhea a complex, rather than a simple problem. To be rational and conscientious in treatment, not only should the general surgical principles, modified as they must be, be employed in every case, but the minutest details in treatment must be observed that will tend to assist the animal organism in its attempt at recovery. Treatment upon these premises can only be rendered practical by simplifying the many details so as to consume as little of the patient's and physician's time as possible.

These conclusions now bring us direct to our subject matter. I have previously spoken of the objects of surgical treatment; they are the obtaining of the following results: rest, surgical cleanliness, reduction of congestion and absorption of the inflammatory exudate for the inflamed area, accomplished in this disease by the elevation of the constitutional condition of the patient to its maximum, by regulation of the diet and bowels, by the administration of tonics when indicated, as iron, strychnin, etc., and by correcting gouty and rheumatic diathesis and other abnormal systemic conditions, if present.

FIRST CLASSIFICATION.

Rest:

(*a*) General physical rest, confinement to bed (seldom possible).

(*b*) Prevention of erections. This necessitates prevention of congestion and irritation of the sexual organs, their nerves and centers and will be considered with the second and third classifications.

SECOND CLASSIFICATION.

Surigal cleanliness:

(*a*) Through mechanical drainage. Meatotomy to the extent of three-fourths of the diameter of the urethra.

(*b*) Through flushing of the urethra by drinking large quantities of water, a glass every two hours (no alcohol, no carbonated waters). Lemonade permissible.

(*c*) Through keeping drainage free, by not applying cotton or other dressing too closely to the meatus and by frequently changing it.

(*d*) Through preventing reinfection from absorption of the infectious discharge that accumulates upon the cotton applied to the meatus, by using an antiseptic upon the cotton.

(*e*) Through always allowing the penis to hang down in order to give the discharge the benefit of gravity.

(*f*) Through having the suspensory fit properly, that is, support the testicles well, and not constrict the penis near its base, thus interfering with the circulation and, by retaining the discharge on the proximal side of the obstruction, endangering the post urethra and, by interfering with the circulation of the distal side, favoring congestion of the urethra, anterior to the obstruction.

(*g*) Through instructing the patient not to strip the urethra and thus disseminate the infection and injure the inflamed membrane.

THIRD CLASSIFICATION.

Reduction of congestion and absorption of inflammatory exudate obtained:

(*a*) Through regulating the diet, in ordinary cases to extent of eschewing highly seasoned foods and pastry, and causing meals to be taken regularly and eaten slowly. Otherwise the natural daily diet, including tea or coffee once a day, which does not appear to affect the inflammatory condition adversely, but rather aids it by diminishing the mental depression that frequently accompanies this disease. In severe cases a fluid diet is indicated.

(*b*) Through instructing the patient to sleep on a hard mattress with light covering. Not to rest on back, because the abdominal organs, gravitating towards the pelvis, by their pressure will cause congestion of the pelvic organs and erections. Prevented by tying a towel about the abdomen and placing the knot in the small of the back.

(*c*) Through instructing the patient to absolutely avoid sexual intercourse, even the loving attentions sometimes deemed necessary to wooing; and all scenes, literature and conversation that will evoke lascivious thoughts and by having him empty his bladder at least once during the night.

(*d*) Through the administration of oleum santali (pure) cc. .60 every two hours, until four doses are taken, then cc. .30 every four hours, if the posterior urethra is involved or the dilution of the urine by ingestion of water does not relieve the irritation caused by the acid urine and urinary solids.

(*e*) Through keeping the bowels free with magnesium sulphate, gm. 3.75, night and morning, thus depleting the pelvic circulation.

(*f*) Through instructing the patient to avoid getting his feet wet and sudden changes of temperature.

(*g*) Through instructing the patient to bathe the penis twice daily, if not oftener, in water as hot as can be borne. This not only diminishes congestion, promotes phagocytosis and absorption of inflammatory exudation, but frees the glued-together meatus and facilitates the escape of the discharge, diminishing the suffering of the patient. If possible a sitzbath should be taken at night. If posterior urethra is involved or erections frequent, in addition an enema of hot water with one teaspoon of salt to the pint is of benefit, and can be repeated in the morning if necessary.

(*h*) Through massage of the seminal vesicles and the prostate (antiseptic precautions being taken) in order to empty the bladder and vesicles of their fluid contents. It is in this procedure that we have a means of preventing erections that are not only excruciatingly painful at times, but as maintained by Oskar Hoffman of Dresden, are the chief causes of gonorrheal metastasis; moreover, the practical benefits derived from this procedure in preventing the extention of the gonorrheal inflammation to the prostate and seminal vesicles, can be best explained upon an anatomic and physiologic basis.

(*i*) Through irrigation of the urethra according to Janet's method, at least once daily, with a hot (100° to 110° F.) solution of potassium permanganate 1-6000. Or one may use any of the newer silver salts, as argonin, argentanin, protargol, largin, argyrol, etc. The object of this irrigation is not to kill the gonococci by means of the germicide used, but to reduce congestion, to render the whole canal of the urethra and the inflamed surface free from the discharge, to stimulate the circulation, to aid phagocytosis and to promote the absorption of the inflammatory exudate.

The principal method of aiding nature to obtain surgical cleanliness (that is direct destruction of the gonococci), I have omitted until the present, though this factor in treatment is important. Alone it is often ineffectual, and this fact is not to be lost sight of, and the preceding factors more essential to success in treatment, forgotten.

I refer here to the various albuminated salts of silver, their apparent inefficiency in many cases being the result of not permitting them to remain long enough in contact with the tissues to exert their penetrative and bactericidal properties effectively. That medicines are not usually allowed to remain long enough in the urethra to be efficient, is strongly brought out by Mr. B. Motz, in an excellent article on the treatment of chronic urethritis in the *Annals des Maladies des Organs Genito-Urinaries*, and the method of using the silver salts that is here given is due to adoption of the principles as advocated by him in chronic gonorrhea and their applications of technic to acute cases.

(*To be continued.*)

PSEUDO-MEMBRANOUS ENTERITIS*

By Wilbur N. Hunt, M. D.

BELLINGHAM, WASH.

This disease, although not very common, occurs with sufficient frequency to make it of interest to the physician, both on account of the difficulty of effecting a cure and the serious results following if allowed to continue uncured.

Various names have been applied to this affection, such as croupous enteritis, chronic exudative enteritis, tubular diarrhea, mucous diarrhea, etc., but the name selected above seems to be the most satisfactory.

The disease is a chronic, non-febrile affection of the intestinal mucous membrane, characterized by the production of shreddy membrane, of a greater or less degree of toughness, which is discharged at varying intervals with a temporary relief of symptoms. In one of my cases this membrane was thrown off in pieces resembling sections of tape worm and was for a long time considered by the patient and her family to be a discharge of portions of tape worm.

Etiology. The etiology is somewhat obscure. It is almost unknown in young children and is not common in youth or old age but occurs with greatest frequency between the ages of thirty and fifty. Of the cases in my own practice, one was a young woman of twenty and another a man of fifty-two. A very large majority of cases occur in women and especially those of neurotic type. In fact the nervous element is a prominent factor in every case. Whether or not there is a bacterial cause for the condition has not been determined, but it is my opinion that the real cause is a disturbance of nutrition of the intestinal mucous membrane, due to defective innervation. The exciting cause may be one of many, such as taking cold, improper food, etc., etc.

The disease does not often follow an acute inflammation and is usually not classed as an inflammatory trouble. It generally begins with obscure digestive disturbances, with some nausea and possibly vomiting, with more or less severe indefinite pain in the abdomen which is often described as a soreness or rawness. Constipation alternates with diarrhea and it may be months before the characteristic membrane is thrown off in sufficient quantity to show clearly the real condition.

Diagnosis. Up to the time of the discharge of membrane the diagnosis may be exceedingly difficult or impossible but after this occurs there should be no trouble in differentiating it from other diseases having similar symptoms. The fact that the membrane in this affection is composed largely of mucin while the membrane in diphtheria, dysentery and other troubles is fibrinous in character is sufficient to distinguish them, especially when taken in connection with other symptoms characteristic of those diseases. The membrane is sometimes discharged with every stool, but usually only once in several days, and occasionally only once or twice a month, when there is a paroxysm of intense pain previous to the removal of the membrane, after which there is a period of comparative relief. During the intervals the stools may be normal in appearance.

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*Read before the Whatcom County Medical Society, Bellingham, Wash., May 9, 1904.

The course of the disease is exceedingly chronic and it is sure to extend over a period of months and is likely to last for a number of years. The nervous symptoms accompanying it are always prominent and may amount to actual hysteria or melancholia, making the patient a most difficult one to manage. A fatal termination from this disease alone is rare but by its depressing effects on the system predisposes to other troubles.

Treatment. In the treatment of pseudo-membranous enteritis a large amount of patience and perseverance is required on the part of the physician as well as the patient. I believe, however, that all cases can be cured if the patient can be kept under control and the treatment is sufficiently persistent. Hygienic measures are of great importance and the diet should be regulated with care. One of the serious problems is the regulation of the bowels and especially the prevention of the constipation which is very common. All irritating cathartics should be avoided but it is of the greatest importance to see that the bowels do not become clogged. When the disease is confined to the colon, flushing with a weak solution of nitrate of silver or other antiseptic is of value, but in those cases where the small intestine is also affected, which is the most common condition, I have not found this to be of much use, except as a relief to constipation.

In one case under my care, that of a nervous and irritable woman, I found juglandin the most satisfactory of any laxative or cathartic that I tried in her case. The ordinary salines or vegetable cathartics, even in small doses, would throw her into spasms of pain. One of the most difficult problems of the many which arise in the management of this disease is that of relieving the pain which occurs at the time of the discharge of membrane. I have usually tried to avoid the use of morphin, but have nearly always been compelled to use it to some extent in every case. If possible I do this without the patient's knowledge of what I am using. In one aggravated case, after I had given morphin hypodermically a number of times, the patient began taking the morphin on his own account and I had almost as much trouble in breaking him of his morphin habit as in curing him of the disease for which it was taken. For the local effect on the intestinal membrane I think the intestinal anteseptics are of some value and of these salol and bismuth have seemed to serve my purpose best. The main reliance, however, I think should be placed on general tonics and alteratives and of these arsenic, iron and mercury have been found most satisfactory.

SOME CHARACTERISTICS OF EASTERN AND EUROPEAN CLINICS.

By L. P. McCalla, M. D.,

BOISE, IDAHO.

(Concluded.)

We sailed from Philadelphia on an American Line steamer to Liverpool. On arriving in Queenstown, however, we landed. This is the prettiest harbor I have ever seen. After a sojourn of eleven days on the high seas, seeing no living thing, it was a very pleasant feeling to sail into this beautiful shaded, calm harbor, surrounded by beautiful cliffs, which are so charmingly landscaped and covered with the soft green so characteristic of Ireland alone—the emerald green. We sailed into this harbor just as the sun rose in all his splendor, sending his beautiful golden rays in contrast with the wonderful blue of the sea, and Ireland's own emerald green, thus casting long shadows far out into the deep waters, and throwing magnificent pictures of the houses along the shore into the mirror of the clear waters. This beautiful spot is pictured forever in my memory, as one of the sweetest recollections of my life's travels.

A six-mile ride from Queenstown up the River Lee, whose banks are marked here and there by some of the beautiful old castles like Black Rock castle, and by such relics as Monkstown, Glenbrook and other grand old ruins, which mark the once magnificent residences of an almost, even in history, forgotten aristocracy, which once were famed for their bravery and warlike deeds, brings you to Cork. This is a queer old Irish city, which is not wanting in peculiarities or beauty, and is in many respects attractive.

After a rest of a few hours in Cork we were driven in one of those funny little Irish jaunting cars six miles out in the country, to the famous old Blarney castle. You have all heard of the Blarney stone, which so many Irishmen are said to have kissed, thus giving them the charm, possessed by no one who has not had this distinction, of most pleasing and winning manners and tongue. This famous stone is the sill of the top front window in the old castle, and stands out about three feet from the main corridor on the inner side, near the top of the castle. In order to kiss this stone, one must be suspended by his heels and stretched across this opening, which looks down three hundred feet, a most dazzling distance, and must hang on to the side of the window with one hand, reach under and kiss the under surface of the charmed stone, which is well worn. It is a daring feat to accomplish, dangerous if you are not sturdy of nerve, but I kissed it just the same.

The next day we traveled by coach and the funny little things they call railway cars, over the prettiest country I have ever seen. We know nothing in America about such marvelously good roads as you find in Europe. At night we came to one of the prettiest little evergreen tropics, so soft, quiet and restful, called Glengariff. After a refreshing rest over night we traveled by coach all day through a charming country, till at dusk we came to the beautiful Lakes of Killarney. This delightful spot is too well known and too often sung of by more poetic tongues than mine to warrant or need any effort of mine to flatter. After a day's rest in this Nature's paradise, we journeyed on to the old Limerick town, which has many charms and relics of antique interest, characteristic of itself.

The next day we journeyed on to Dublin, where we found an up-to-date, modern city. For certain forms of natural beauty, memorials of Druid paganism, wonderful prehistoric relics and priceless souvenirs of primitive Christianity, Ireland has no equal in the world. If one begins by pitying, he ends by loving her.

In Dublin we visited the famous Rotunda Hospital, which, for obstetric and gynecologic diagnosis, is the best place I have seen. You pay a nominal fee, which entitles you to take part in the work of the hospital as an interne. You have the privileges of the institution, examine any and all patients you desire, and assist at, and do some of the operations. This may also, and usually does, include your residence in the hospital. This, in my judgment, is the best opportunity I have seen and is the best way to take any course of this kind. The hospital training is so beneficial, especially to those who have not had hospital interneship work. The master of this hospital lives in the hospital and receives seven thousand pounds a year. This is the greatest honor one can have paid him in that line of work in Ireland. There are other good hospitals in Dublin. and we were shown many courtesies in each, having the pleasure of seeing the great Irish surgeon, Dr. Ball, again at work.

Dr. McCann is the best gynecologist in Dublin. He is past master of the Rotunda, having lately finished a seven years' mastership. Irish gentlemen are most hospitable and are the true type of gentlemen. They have warm places in their hearts for Americans.

After a week in Dublin, we took boat for Glasgow. Here the leading spirit in surgery in all Scotland, Sir Wm. MacEwen, is doing great work. He, too, is a prince of men and is very cordial to all Americans. Sir William was offered the chair of surgery in Johns Hopkins when it was organized, as you may already know, and was very much interested in their work and, I think, feels that he wishes he had taken it. However, there is no reason for his being in any way dissatisfied with his position there, which is the supreme head of the surgical work in the great university school. I had the pleasure of seeing all his work while there, and also the honor of taking tea with him on two occasions.

Our next stop was in Edinburg, where there is one of the largest and best-known medical universities in the world. Many great men are there, but the student of surgery will not tarry long, since they have never advanced beyond the antiseptic era, and have no appreciation of asepsis. Prof. Annandale boasts that he now wears the same rubber apron which he first wore in the hospital, and that it has never been washed since he has been wearing it. To see a surgeon take his hands out of his trousers pockets and go to work without washing them again is too much for the average American, who is a stickler for his technic, if anything. Glasgow is a beautiful modern city, very much of the style of New York. Edinburg is a pretty city, has many beautiful old castles around it, and is a great resort for tourists and all who appreciate historic places.

Our next stop was Leeds. This is a great manufacturing city, dingy and smoky. Mr. Mayo Robson formerly lived here and still holds a place on the staff of the hospital. He has done great work here, has amassed a fortune and today lives in a fashionable part of London, and does only private work. I had the good fortune to have a letter of introduction to him from Baltimore, which enabled me to see all his work while there.

Mr. Robson is the best abdominal surgeon I have yet seen. His gallbladder and stomach work is grand. He has also done more in the surgery of the pancreas than any one to my knowledge. I could see where Will Mayo, with all respect to this great American, had gotten many of his pointers in this kind of surgery. This, however, is all the more to his credit, as Mr. Robson is undoubtedly the master in this line of work.

Mr. Robson was working out a diagnostic point of value in pancreas and stomach-gallbladder work at that time, which he has since published, I think. He found that certain crystals, called pancreatin crystals, found in the urine, dissolved in less time in sulphuric acid than three minutes, usually in one-half to one and a half minutes, means chronic pancreatitis; while if three minutes or more in dissolving means carcinoma, either of stomach, gallbladder or pancreas. I cannot give the method of obtaining these crystals from memory, as it is a fine chemical test, but am promised a copy of the paper when perfected and published.

Mr. Robson uses his bone bobbin in doing anastomosis work, and I like it very much, as it does all that any mechanical thing can do in suturing the ends of the gut or stomach, and is absorbed inside of forty-eight hours. One of the speakers at our last state meeting last fall expressed himself as being surprised at any one mentioning the bobbin in this work, as he could do it in fifteen minutes without it. That may be, but many of the cases on which any one will do a gastroenterostomy in fifteen minutes by suture, without any mechanical help, will die from imperfect closure, and this is much to be regretted, as a rule, both by the operator, the patient and their friends.

Mr. Moynahan, who has also achieved a great reputation in this kind of work, and who was for years associated with Mr. Robson, also lives in Leeds. He read a paper before the surgical congress in Washington last May, and made a most favorable impression on our American surgeons while here.

Our next stop was London. There are numbers of good men, both surgeons and physicians, in London, but there are always a few who interest us most. I think nowhere in London did I see more interesting hospital work than in the University Hospital.

Mr. Barker is one of the two main surgeons here, and I think I received more benefit from his work than any other in London. He is a very clever abdominal surgeon, and I learned much from him in stomach diagnosis. His local anesthesia work is the best I have seen. He has perfected the eucain beta with adrenalin chlorid solution one to one thousand of the former, and one to a hundred thousand of the latter, in normal salt solution. With this local anesthetic he does radical herniae, removes tumors, does amputations and many abdominal sections, and the patients are entirely free from pain. There is much more to be learned about local anesthesia than the kind of anesthetic to use. One of the main points urged by Mr. Barker is one which has been especially worked out by our own Harvey Cushing, of Baltimore. That is the use of the local anesthetic injected into the nerve, or in its immediate vicinity. Mr. Barker says that it is not necessary to inject the anesthetic into the nerve, but it is sufficient to inject it in the immediate vicinity. Another point that he makes in connection with the radical hernia operation is that there are little nerve filaments passing upward from the perineum, and that in the male it requires the thorough injection into the tissues between the tuberosity of the ischium and the scrotum, and in the female between the tuberosity and the labia. Also, in the female, to inject thoroughly into the vicinity of the round ligaments. In fact, this round ligament is the most difficult part in which to get complete analgesia. I have seen young nervous women and girls cheerfully talking to the attending nurse during a radical hernia operation, entirely free from all pain. This local anesthesia makes it often possible to do operations on patients in whom there are contraindications for general anesthesia, and, too, in some patients who are afraid, or thoroughly dislike to take chloroform or ether, or any general anesthetic. It also does away with one assistant, and the patients are relieved of the nausea, vomiting and other disagreeable feelings.

Lord Lister does not operate now. It is difficult, too, to see Prof. Treeves, as he does only private operative work, having given up his hospital connections. There are many surgeons and physicians here of renown, but only a few whom I think are of more than ordinary ability. Bland Sutton, as an operator and pathologist, is a marvel. He is even greater than Howard Kelly in his operative ability and is a great pathologist as well. His work is most interesting and. but for his almost contempt for asepsis, his work could not be improved upon.

Sir Victor Horseley does the boldest brain surgery of any man in the world. His results, too, cannot be equaled by any. He will open the skull and remove portions of diseased brain with as much impunity as any of us would open a boil. His work is extensive and eagerly sought by brain and nerve surgeons from all parts of the world.

The medical work in London is very fine. Nowhere have I seen finer clinical teachers than Barlow and Roberts. The eye hospitals are more numerous in London than any city in the world, and I am told splendid work is done. There is one man in London who is a marvel, a genius. Old Sir Jonathan Hutchinson is the English Osler, and his clinics at the Polyclinic, which are made up of rare and difficult cases brought in by the physicians themselves for his diagnosis, are unique and intensely interesting. His diagnostic ability, especially in rare skin and surgical lesions, is marvelous, and it is a hackneyed saying over there that when they find anything they can't diagnose they take it to Mr. Hutchinson. Surgery in London on the whole is poor. They are far behind America and Germany in technic and knowledge of pathology.

From London we went to Paris, but here we only remained a short time, as we knew no French, and the best men, like Doyen and Pozzi are not so accessible unless you know French well and can handle the outside guides.

From Paris we went to Berne, Switzerland. Here to my mind is the best surgical ability and opportunity given in all Europe for general surgery. Prof. Kocher is a wonderful little man and has more energy (as he begins work at 7 a. m. and works until 3 to 4 every day) than any man I have ever seen. His methods of teaching surgery are to make his ward rounds from 7 to 8 a. m. Here he shows his operated cases of the past few days, and their methods of after-treatment; from 8 to 10 a. m., his clinic. Here he brings in cases of interest, and in the symposium method, showing several of the same kind of disease; and nowhere have I ever seen such surgical diagnostic insight or ability to bring out clearly all the most possible and hidden secrets. He also demonstrates the surgical specimens removed the day previous, and gives a most interesting surgical pathologic teaching. From 10 a. m. to 2:30 or 4 p. m. he operates. After the first two hours, when the students must go to their other classes, his work is most accessible, and if you have the nerve to stay with him he will show you lots of intensely interesting and good surgical work, in close proximity.

After a month here we went to Basle, Freiburg, Heidelberg and Frankfort, thence to Berlin, only making short stops in those places, as time would not allow longer stops.

In Berlin the men of most interest are Von Bergman, Koenig, Korte, Sonnenberg, Oldshausen, Israel, Mackinrodt, V. Leyden, Ewald, Landau, Gusserow, Orth. All these men are masters and their method of teaching as described of Kocher.

Von Bergman's clinics are the most representative, probably, in Berlin, and his surgical dissertations the most scientific to be heard in the world. His accent, on account of facial paralysis, is very poor and even by Germans is hard to understand.

Koenig is the best bone surgeon, and in his clinic you see an immense number of bone cases. It is surprising to one who lives in our Western states to see the great number of tuberculous bone cases, which are presented for clinic and operation there.

Makinrodt's work in carcinoma of the uterus is the most thorough in the world and his results marvelously good. This operation is the most extensive and thorough thing I have ever seen done, being a complete clean dissection, from the umbilicus to the floor of the pelvis; removing all cellular, fat and areolar or gland-bearing tissue; yet, he says, his mortality is not higher than other men's who do only the complete abdominal hysterectomy. It is interesting to hear his claims and see his results and then hear such an eminent man as Kustner, of Breslau, whom I heard, say that Oldshausen's statistics were as good as any ones, and he advocates only the removal of the uterus by vagina, removing nothing but the uterus. Of course this claim is based on the average life of all cases, as he says, and justly, too, that the operative mortality is so much lower; that the mean average of life, is, after all, taking all cases, as long as in Makinrodt's cases.

Makinrodt lays much stress on the hope and possibility of cure, justifying a higher mortality operation, and he, too, is right. It seems to me that the patient should be given her choice as to whether she desires the complete operation with hope of cure, or the palliative.

The teaching of medicine by the Germans is on a higher plane, too, than is the teaching in most of our medical schools over here. They go thoroughly into the preparation of a student, giving him a thorough education in chemistry, physiology, pathology, etc.; and truly such preparation is much to be desired and followed in our country.

I saw the wonderful Epediscope in Koenig's clinic, an electric magic lantern on a gigantic scale, in which you can place a tumor of most any size and get a clear picture on the screen, so as to enable you to differentiate the different kinds of formation and hence diagnose ordinary cases as to whether benign or malignant, and kind of tumor, etc. You can also throw a microscopic slide picture just as seen under the microscope, only magnified thousands of times, making a large picture four by six feet and thus bring out all its parts most delightfully. Also you can place pictures, cuts, etc., with the same magnificence.

From Berlin we went to Breslau, and here saw the world-famed Mikulicz, who to my mind ranks alone with Kocher, and the pair, the two best surgeons in the world. Mikulicz is a wonder, too, and his methods and work along all surgical lines and methods much as Kocher's, yet the many original features of his work and his strong individuality are intensely interesting and instructive. After three months in Berlin I could only remain three weeks in Breslau, in order to make Vienna in season before the time for home-coming. So I journeyed on to Vienna, where there is more work, and the one big hospital where everything is going on and where you can get anything you want.

Outside of Von Eiselberg, Krobak, Nothnagel, Schaute, Neusser, Neuman and Lorenz, you find in Vienna, as in Berlin, an hundred lesser lights, yet most excellent men, who have all kinds of private courses for you, and every man can have anything he desires by the paying of a reasonably small fee. Clinical material in Vienna is most plentiful, and nowhere can you obtain better private opportunities for any or all branches of medicine and surgery. Nowhere in the world can you see such a skin clinic as in Vienna, truly marvelous. And all the possible ailments of a man's hide are there in great numbers. Vienna, as Berlin, is a beautiful modern city, and is second alone to Paris for its grand palaces and buildings, beautiful parks, drives and women. You never can get enough is the one great drawback.

In Dresden, which is the American tourists' Mecca, there are two of the finest hospitals in Europe, Crede's surgical and Leopold's gynecologic and obstetric. Most excellent work is done in both.

It is true that you find in each country of Europe so much that is beautiful, so much that is interesting and fascinating, as the beautiful scenery of Switzerland, the snow-clad Alps standing forth in all their majestic grandeur, the beautiful foothills with luxuriant verdure, the placid, serene lakes with all that nature and art for a thousand years can make them, that to attempt to even picture any description of Nature's beauties, of art or of science treasures in one short and poorly written paper as this necessarily must be, is to do it gross injustice, and I trust you will pardon me for doing no better.

NORTHWEST MEDICINE

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THE FIFTEENTH ANNUAL SESSION OF THE WASHINGTON STATE MEDICAL ASSOCIATION

Will be held in Seattle, July 12, 13 and 14.

It will be possible to secure reduced railroad rates that will especially benefit the profession from east of the mountains if everyone attending the meeting will keep the matter in mind and purchase his ticket with this end in view. Fifty full fares must be paid to Seattle, on either the Northern Pacific or Great Northern road. At the time of purchase a receipt must be taken for the fare paid, which is to be endorsed by the Secretary of the meeting. If fifty or more of these are received the holders will be entitled to return tickets for one-third fare. In order thus to benefit those living at a distance, the members from the Sound region must utilize the railroads instead of steamers. They should remember that a ticket counts the same whether the distance traveled is ten or three hundred miles. Also this rate applies to visitors from Oregon or Idaho. Thus it lies with the physicians near Seattle to bring this financial advantage to those in distant parts of the state. This prospect will naturally favor a larger attendance and increase the interest in the session. We trust this important matter will not be forgotten.

THE PATENT MEDICINE CURSE.

Under the above title Mr. Edward Bok writes a vigorous editorial in the May issue of the *Ladies' Home Journal,* in which he protests against such a prevalent use of bitters and nostrums instead of seeking competent medical advice. He gives a long list of the so-called "patent medicines," showing the high percentage of alcohol which they contain, and draws a striking picture of "a mother who would hold up her hands in holy horror at the thought of her child drinking a glass of beer, which contains from two to five per cent. of alcohol but gives to that child with her own hands a patent medicine that contains from seventeen to forty-four per cent. of alcohol—to say nothing of opium and cocain."

He scores the officers of the Woman's Christian Temperance Union, and admonishes them to open a campaign against the "patent medicine" traffic, and especially against the advertisements of these "dangerous concoctions" which fill the columns of the religious papers of the country.

As Mr. Bok's article will reach about five million readers, the medical profession should heartily applaud him for his outspoken stand on this, as well as kindred subjects. We advise its perusal by all our readers.

PRELIMINARY PROGRAM FOR THE STATE ASSOCIATION MEETING.

The guest of the Association from the East will be Dr. Alfred Stengel, of Philadelphia, Professor of Clinical Medicine at the University of Pennsylvania. He will deliver two addresses, the titles of which will be announced in our next issue. The following papers have been promised which will be supplemented by others that will appear on the final program. The Committee of Arrangements has in view several social affairs of interest, the details of which will appear later. It is hoped that the attractions offered will result in bringing the largest attendance and making this the most profitable meeting on record.

PRELIMINARY PROGRAM.

President's Address	F. H. Coe, Seattle
What is Fever?	Woods Hutchinson, Portland
Tuberculosis	Ivar Janson, Seattle
Diagnosis of Obscure Tubercular Disease	H. M. Read, Seattle
The Role Played by the Nose and Throat in the Etiology of Tuberculosis	Hamilton Stillson, Seattle
Heart Failure due to Acute Indigestion	L. R. Markley, Bellingham
Some Practical Points on General Paresis	W. T. Williamson, Portland
The Early Diagnosis of Tabes Dorsalis	J. E. Harris, Seattle

Headache, a Disease .... R. W. Perry, Seattle

Defects of Eyes, Nose and Throats of School Children.................................... A. W. Hawley, Seattle

Squint and the Fusion Function......... David DeBeck, Seattle

Sarcoma of the Choroid, with report of Cases................................ A. J. McKinnon and J. W. Bailey, Seattle

Helps and Hindrances to Proper Pre-natal Conditions.................................... W. C. Hastings, Seattle

Surgical Treatment of Uterine Displacements... R. C. Coffey, Portland

Gumma of the Ovary................ J. W. Scamell, Aberdeen

Report of a Case of Perforation of the Gallbladder in Typhoid Fever, with Remarks on the Diagnosis and Treatment....................................... P. W. Willis, Seattle

Intestinal Intussusception............... W. S. Durand, Everett

Traumatic Perforation of the Intestines.... E. M. Brown, Tacoma

Gastro-Enterostomy With Elastic Ligature... C. A. Smith, Seattle

Some Unfortunate Experiences in Surgery... E. E. Shaw, Walla Walla

Removal of the Prostate, Prostatic Urethra and Prosthesis of the Remaining Canal .... M. A. Nelms, Walla Walla

The Treatment of Congenital Dislocation of the Hip.. P. W. Willis, Seattle

Injuries of the Spine, with Report of a Case.. W. C. Cox, Everett

The Treatment of Burns............... G. B. Smith, Anacortes

Extensive Injury Occasioned by a Burn, and an Account of Some of the Methods Resorted to in Treating the Same....................................... H. R. Keylor, Walla Walla

The Prophylaxis of Syphilis and its Sequelae... Wm. House, Portland

Humanity and Common Sense versus Idealism in Venereal Prophylaxis .... G. S. Peterkin, Seattle

The Uses and Abuses of the X-ray.. N. G. Blalock, Walla Walla

Electrical Treatment of Chronic Constipation... J. R. Harvey, Sunnyside

The following have promised papers, the titles of which will be announced later: K. A. J. Mackenzie, Portland; C. J. Lynch, North Yakima;.

By-Laws, Chap. II., Sec. 4. No address or paper before the Association, except those of the President and orators, shall occupy more than twenty minutes in its delivery.

MEDICAL NOTES.

The Bingham Tuberculosis Sanitarium. It is a pleasure to record the opening of a tuberculosis sanitarium, near at home, so situated as to assure the desired conditions for the favorable treatment of this disease. This one is established by Dr. J. E. Bingham, of Walla Walla, in the Blue Mountains of Oregon, not far from the Washington line, in an ideal spot for out-of-door life. It is on the O. R. & N. railroad, at Gibbon, Ore. Under the modern, approved treatment of tuberculosis patients at this sanitarium ought to exhibit favorable progress toward recovery. We wish success to Dr. Bingham and his sanitarium.

Typhoid Phophylaxis at North Yakima. The State Board of Health held a meeting at North Yakima, May 28. The subject of chief consideration was the prospective typhoid of the coming summer. Thorough sanitary methods have been carried out during recent months that have practically eliminated the disease for the present, only a few cases being reported monthly. Sanitary inspectors will systematically visit all possible sources of infection during the summer. Every case of fever, the cause of which is not otherwise satisfactorily explained, will be considered as typhoid and so treated until proven not to be such. The state, county and city boards of health have engaged Dr. Rose Bebb, formerly of the New York Department of Health, as bacteriologist, who will devote the next six months to bacteriologic work at North Yakima, making analyses of water, milk, etc., as well as the work pertaining to the cases themselves of the disease. By these procedures it is expected to prevent a recurrnce of a typhoid epidemic.

Snohomish County Society Meeting and Smoker. The Society held its May meeting on the 17th, at Everett, President Mead being in the chair. There was an attendance of twenty-five, including the following visitors: Drs. Coe, DeBeck and Heg, from Seattle; E. M. Brown, Bean, Quevli and Yocum, from Tacoma.

The following program was presented:

The Refraction and Accommodation of the Eye ....Dr. Manning
Symposium on Pneumonia—
  Etiology and Symptomatology ....Drs. Adams and Cox
  Pathology and Bacteriology ....Dr. West
  Prognosis and Treatment ....Dr. Sturgis

A general discussion followed in which all present participated.

The meeting adjourned to a smoker, which proved a very enjoyable affair.

Toasts were proposed and answered as follows:

1. Our President ....The Chair
2. Our Guests ....Dr. Cox, responses by Drs. DeBeck and Quevli
3. The State Medical Society ....Dr. Coe
4. The Medical Man's Recreation ....Dr. Bean
5. The King County Society ....Dr. Heg
6. Importance of Medical Societies to Members of the Profession ....Dr. Brown

7. The Pierce County Society ....Dr. Yocum
8. City of Everett ....Dr. Manning
9. The Ladies ....Dr. Betts

First Annual Meeting of the Montana State Medical Association. An interesting meeting of this Association was held at Butte May 18 and 19.

The following program was presented:

1. Address by the President..................Louis Bernheim, Butte
2. Treatment of Acute Middle Ear Diseases..Jno. A. Donovan, Butte
3. Abscess of the Liver...................J. F. Spelman, Anaconda
4. Cellular Co-operation and Conflict....Ernest Crutcher, Great Falls
5. Conventionalism in Medicine..........J. H. Owings, Deer Lodge
6. Personal Experiences in Use of the X-Ray....D. Campbell, Butte
7. Gall Stones ....T. J. Murray, Butte
8. How Should the Country Doctor Manager His Major Operative Cases? ....H. H. Townshend, Melrose
9. Report of a Case of Ichthyosis............W. B. Parsons, Missoula
10. Obdominal Notes ....I. D. Freund, Butte
11. Some Remarks on the Treatment of Puerperal Sepsis, with Special Reference to the Present Status of the Curette.. ....E. E. Sutherland, Sheridan
12. Prostatic Hypertrophy; It's Treatment and Cure........... ....G. W. King, Helena

The following officers were elected for the ensuing year:

President—B. C. Brooke, Helena.
First Vice-President—Jno. A. Donovan, Butte.
Second Vice-President—E. F. Conyngham, Philipsburg.
Third Vice-President—C. F. Hopkins, Chinook.
Secretary—Grace W. Cahoon, Butte.
Treasurer—I. D. Freund, Butte.

TO OUR READERS AND CONTRIBUTORS.

All material for publication must be received by the twentieth day of the month preceding a given issue. Articles will be illustrated by half-tones or etchings when accompanied by photographs or drawings for the same. Reprints of contributed articles can be obtained at the cost of publication, from the Metropolitan Press, publishers of the journal. A limited number of additional copies of the journal will be supplied to contributors, if a request is made for them.

TO ADVERTISERS.

We wish to call attention to the fact that NORTHWEST MEDICINE has no department for reading notices, publishers' notes, etc., and that the literary and advertising pages are entirely distinct.

REPORTS OF SOCIETY MEETINGS.

KING COUNTY MEDICAL SOCIETY.

President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

The first regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce, on the evening of May 2, President Heg being in the chair. Thirty members and visitors were present. The name of Dr. H. E. Allen was proposed for membership.

PATHOLOGIC SPECIMENS.

A Collection of Calculi. Dr. Raymond exhibited two gallstones obtained by operation from the common duct, from two patients. One was of unusual size, being about one and one-half inches long by one inch thick. He also presented a salivary calculus, obtained from operation, of dimensions about three-quarters by one-half inches. Next were several bronchial calculi, similar in size to grains of wheat, which a man has expectorated at intervals for a long time. He also exhibited a prostate, secured from an autopsy, filled with calculi.

PAPERS AND DISCUSSIONS.

Acute Leptomeningitis. Dr. Bailey read this paper, describing the history of the disease and its appearance as a primary or secondary condition. He gave the pathology, symptoms, prognosis, diagnosis and treatment. This was supplemented by interesting and instructive descriptions of four cases in adults, that occurred in the doctor's practice.

Drs. Raymond, Willis, Read and Eagleson discussed the paper, especially as to diagnosis and treatment. Drs. Stillson, DeBeck and Pontius referred particularly to eye symptoms and complications, and their bearing on diagnosis.

Perforation of Gallbladder from Typhoid Infection. Dr. Willis read a paper describing a case of typhoid in a child, in whom, late in the disease, appeared symptoms of acute abdominal disturbance in the right upper quadrant. A diagnosis was made of probable ulceration and perforation of the gall bladder. The diagnosis was confirmed by operation. The patient rallied and progressed favorably for some weeks. Then death ensued from adhesions of abdominal contents. The doctor recited the history of this condition and information obtainable from medical literature.

Dr. Eagleson said he had seen the child and advised against operation, as he considered death certain. The patient would have recovered except for the subsequent adhesions. He referred to a report of 70 cases in which typhoid bacilli were found in the gall bladder, of whom 30 died. He stated that only seven cases beside this are reported in the literature of successful operation. He quoted several cases of gall bladder operations in which the typhoid bacillus was found in the gall bladder. One writer suggests that this may account for relapses of typhoid, as they are found there months after the attack of fever.

Dr. Miles referred to a case of his with perforation, in which he thought an operation might have effected a cure, as the postmortem showed a small perforation in the gall bladder that had apparently begun to heal.

Dr. Heg had seen two patients with all the signs of perforation, who recovered. He thought they might have been cases of small perforations. He operated on one patient who died but, under similar circumstances, he would do so again.

Dr. Willis thought that, when a patient recovered after a perforation was supposed to have occurred, the diagnosis was wrong.

The second regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce, on the evening of May 16, 1904, President Heg being in the chair.

Thirty-five members and visitors were in attendance.

PAPERS AND DISCUSSIONS.

The Feeding of Well Babies. The first paper was read by Dr. Hastings, on this subject. He mentioned the lamentable fact that so many mothers prefer, for many reasons, not to nurse their babies, and emphasized the necessity of insisting on their doing so when possible. For artificial feeding he prefers suitable mixtures of milk, boiled water and sugar of milk. He approved sterilizing the milk by boiling, to kill bacteria, and overcoming constipation by proper selection of fruits, etc. At times it seems necessary to employ artificial foods, at the same time recognizing the danger of rickets and other ailments being induced. He condemned condensed milk entirely and endorsed the giving of an abundance of cold water.

Dr. Smith called attention to recent criticisms of scientifically modified milk on account of the different chemical compositions of the same ingredients in the milk of the cow and mother. This may explain the failure of a food to nourish the child when its composition appears. identical with that of the mother. He spoke of the success, in many cases, of simply diluting the milk with barley or oat meal water, with or without lime water.

Dr. Sharples referred to the troublesome constipation caused by modified milk and approved of the use of barley water as a diluent. He gave personal experiences of scurvy caused by condensed milk, in the early years of practice, and condemned its use.

Dr. Turner mentioned the difficulties of the digestion of the casein and that it was aided by the use of cereal diluents and lime water.

Dr. Eagleson thought we ought to patronize home industries when they are worthy of our support and inquired the experience of the members in the use of Sanitas Puritas, a baby food manufactured in our midst, which is claimed to be ideal in composition and a perfect imitation of mother's milk.

Dr. Clark said he had tried it, but with poor results, and had given up its use.

Dr. Hawley said the Borden Co. had employed a chemist for years in the attempt to manufacture a milk like that of the mother and had failed to obtain it. He doubted whether this one was of real value.

Dr. Tripp stated he had a baby on this food that was in a flourishing condition. Also he had another on the ordinary condensed milk, made by the same company, without his knowledge, who appeared to thrive on it.

Dr. Janson spoke favorably of the use of whey which, being deprived of the casein, is thus less objectionable. By the addition of cream in suitable quantities it can be made a satisfactory food.

Dr. Read emphasized the importance of the mother nursing the baby. We should not consent to use of the bottle unless forced to it. The bottle-fed babies have bowel troubles from the lack of the ingredients of the mother's milk. The breast-fed babies are less liable to sickness in later life.

Dr. Heg referred to a contention on the matter of milk where the State Dairy Commissioner claimed the milk to be good because it contained no formaldehyde. The State Board of Health analyzed nine samples and found pus in three, excessive bacteria in three others, and only three without these objections. He hoped the recently established City Laboratory would be utilized for the bacterial examination of milk, which is most important.

Dr. Eagleson mentioned the reported lessened death rate among children in Chicago since the milk has been subject to this form of examination.

Some Practical Points Concerning Operations Through the Male Perineum. Dr. G. M. Hawley read this paper. He described the preparation of the patient, dwelling especially on the necessity of having the bowels empty. The question of anesthetic was discussed, ether being preferred as a rule. He prefers the straight median incision except where a urethral guide is impossible, when one of the transverse variety is used. He described the details of entering the perineal structures. Concerning strictures he stated that those of the membraneous urethra do not exist, deep strictures being in the bulbous portion. He advocated subsequent drainage of the bladder and described the technic of applying and securing the drainage tube, also its subsequent action as a syphon. The necessary post-operative treatment was given, to combat fever and shock.

Dr. Peterkin thought the greatest difficulty was in having the patient properly cared for subsequent to operation, and gave suggestions to this end. He thought the catheter caused pain if in too far. If held tightly in place with a bandage it was painless.

Dr. Raymond did not agree concerning deep strictures. He has seen several cases of stricture behind the triangular ligament, and has one under treatment. He did not approve of bladder syphonage because the apparatus would not work when the bladder was empty.

Drs. Miles and Sharples further discussed the paper.

Dr. Hawley said the word syphon was perhaps improperly used. He meant a rubber tube, not catheter, just inside the bladder which draws the urine as soon as passed. It is surgical and comfortable for the patient.

WHATCOM COUNTY MEDICAL SOCIETY.

President, D. E. Briggs, M. D.; Secretary, W. N. Hunt, M. D.

The Whatcom County Medical Society met in regular monthly session May 9, 1904, at Odd Fellows' building in Bellingham. Dr. F. J. Van Kirk, Vice-President, occupied the chair.

The committee on admission and ethics reported favorably on the application of Dr. A. T. Kaupp, and he was duly elected to membership.

The paper of the evening was presented by Dr. W. N. Hunt, on the subject of Pseudo-Membranous Enteritis. (See page 236.)

The writer referred to some of the difficulties encountered in the management of this disease as illustrated by cases occurring in his own practice.

The discussion which followed was participated in by nearly all present.

Adjourned to meet June 13, 1904.

SOUTH IDAHO DISTRICT MEDICAL SOCIETY.

President, H. A. Castle, M. D.; Secretary, E. W. Kleinman, M. D.

The Society met in the city hall in Boise, at 10:55 a. m., April 7, 1804, President L. C. Bowers presiding.

The usual minutes and reports were read and approved.

The name of Dr. G. A. Kellogg, of Nampa, proposed for membership, was reported on and he was duly elected.

PROGRAM.

The following papers were read and freely and profitably discussed:

Hip Joint Disease, by Dr. J. L. Stewart, Boise; Eclampsia, by Dr. C. L. Sweet, Boise; Case Reports; Two Cases of Tuberculosis of genito-urinary tract, by Dr. Geo. Collister, Boise; Insanity, by Dr. Mary Calloway, Boise; Extra Uterine Pregnancy, by Dr. W. D. Springer, Boise; Autointoxication, by Dr. Geo. Haley, Boise; Old Age, by Dr. J. K. Dubois, Boise.

Recess until 7:30.

Eyes of School Children, by Dr. Adolph Blitz, Boise; Quarantine, by Dr. John Boeck, Boise; Opthalmia Neonatorum, by Dr. L. Wardell Boeck, Boise.

The meeting adjourned to the banquet table, at Overland Hotel where Dr. L. P. McCalla, of Boise, Idaho, read his paper entitled, Some Points of Interest in a Year's Post-graduate Course in the United States and Abroad.

Dr. O. B. Steele acted as toastmaster, many toasts being responded to and much bnsiness attended to.

The following officers were elected for the ensuing year: President, H. A. Castle, of Pocatello; Vice-President, O. B. Steely, of Pocatello; Secretary-Treasurer, E. W. Klemman, Shoshone.

The Society adjourned to meet at Idaho Falls the first Saturday in July.

RECENT PROGRESS IN MEDICINE AND SURGERY.

SURGERY.

Edited by

J. B. Eagleson, M. D.; E. E. Heg, M. D.

Operation in Spinal Cord Injuries. By Drs. S. J. Mixter and H. M. Chase, Annals of Surgery, April, 1904.

The authors report two cases operated on by Dr. Mixter, both injuries of the cervical vertebrae, the first involving the 4th, 5th and 6th and the second the 6th and 7th.

Both cases showed consciousness with complete paralysis, sensory and motor, below the injury; slight motions in flexion of arms and diaphragmatic breathing, or symptoms typical of complete transverse lesion of the cord; one case recovered with minor disabilities and the other lived eleven months, during which time there was marked improvement, death being due to a right nephrolithiasis with pyelonephritis and systitis. Microscopic sections of cord showed descending degeneration of injured axones below the level of the lesion in motor tract and of the common tract of the short descending sensory collaterals from the inqured sensory neurones; also ascending degeneration of the injured sensory axones. It also demonstrated that normal sensory and motor axones existed at the seat of the lesion, though their functions were interrupted at the time of injury, giving symptoms of total destruction of the cord.

The conclusions are, that in injuries of the cord even where the symptoms are such as to indicate a complete transverse lesion, an operation is not only justifiable but indicated, as it removes depressed fragments of bone and blood clots, allows escape of exudate, makes room for inflammatory thickening, relieves pressure from the cord and pressure has been shown to cause degeneration within four days; gives greater space for possible traumatic spinal edema and the dangers of the operation are slight compared with the possible benefit to be derived and the satisfaction given by the knowledge that continued pressure has been removed. Heg.

Penetrating and Perforating Gun-Shot and Stab Wounds of Abdomen. Dr. James Y. Brown, New York Med. Journ., April 16, 1904.

He believes all cases of wounds of the abdomen should be prepared as for laparotomy before examination, the wound enlarged if necessary and traced with the finger to determine whether or not it penetrates the peritoneum. If the wound penetrates, the only way to determine perforation of the viscera is by an operation which should always be done, notwithstanding the opinion of the surgeons of the Spanish-American and Anglo-Boer wars was to the contrary. Senn's hydrogen gas test for perforation of the bowel he considers unsafe because of the danger of fecal extravasation in cases of perforation.

He uses the median incision, preferably from the ensiform to the umbilicus in gun-shot wounds; a systematic examination of the viscera being more easy and thorough by such incision. For stab wounds the incision is governed by the locality and size of the original wound. A systematic and thorough examination of all the abdominal viscera is absolutely essential to avoid overlooking injuries. The control of hemorrhage by ligature, sutures or packing must be done thoroughly.

He believes in thorough irrigation with salt solution at end of the operation and in cases of shock always fills the abdomen with salt solution on first opening the abdomen. He always drains after bowel injuries, prefering a glass drainage tube placed through a stab wound just above the pubis, with the patient in an exaggerated Fowler position. As time is of great importance in most cases he uses the Murphy button for intestinal anastamosis and in bad cases closes the abdomen with properly applied through and through silk worm gut sutures.

He reports 9 cases of injury to the stomach or intestines, of whom 3 died and 6 recovered; of the latter one died 13 days after operation from pneumonia, having been operated on a second time 48 hours after the first operation because of intestinal obstruction. He also reports 5 cases of injury to the liver where there was no intestinal lesion, of whom 4 recovered and one died from shock.

In addition there were eight cases where the wounds penetrated the pertioneum but operation and careful search failed to locate any injury of the abdominal viscera; these all recovered. HEG.

Gastro-Enterostomy for Simple Ulcer of Stomach and Duodenum.

By B. G. A. Moynihan, M. D., Annals of Surgery, May, 1904.

The writer gives an interesting analysis of 100 cases of ulcer of the stomach and duodenum treated by gastro-enterostomy, with a mortality of only two per cent..

Eighty-five cases were operated upon for chronic ulcer with intractable dyspepsia, or dilated stomach, with one death. Fifteen cases were operated upon for profuse and recurring hemorrhage, with one death. Fifty-six were females and forty-four males. The ages ranged from seventeen to sixty-two, the average being thirty-five.

In a large percentage of the cases more than one ulcer was found in the stomach. In nine cases the ulcer was found in the duodenum alone, while it was accompanied by one or more gastric ulcers in thirteen.

The anterior operation of Woelfler was performed in five cases, the posterior of von Hacker in ninety-four, and Roux's operation in one case.

In concluding, he sums up his experience as follows: "The operation of gastro-enterostomy is so safe and its results are so good that I cannot doubt that it is the most desirable operation in all cases of chronic gastric ulcer. Its success depends in no small measure upon the care in the preparation of the patient, speed in operating, the choice of a method which is simple, and which does not need a long exposure of viscera, and upon many details in after-treatment. Excision of an ulcer is perhaps desirable in some special instances, but the main indication to be fulfilled is drainage of the stomach, and, to secure this, gastro-enterostomy should always be performed. In many cases in this series the patients were extremely ill, wasted, and enfeebled to the last degree, and it was only by exercise of the greatest care that the operations proved successful. Now that the mortality is reduced to so small a figure as 2 per cent., the surgeon may not unreasonably expect that, from being a last and sometimes desperate resource, gastro-enterostomy may be considered as a method of treatment worthy of consideration in a much earlier stage of chronic ulcer of the stomach." EAGLESON.

OPTHALMOLOGY, RHINOLOGY AND LARYNGOLOGY.

Edited by
R. W. PERRY M. D.; A. W. HAWLEY. M. D.

Alarming Hemorrhage Following Tonsillotomy.—By Dr. Harmon A. Smith, Laryngoscope, February, 1904.

The main idea of the article is to impress the usefulness of the tonsillar hemostat. The writer discusses the causation of post-operative hemorrhage and believes that hemorrhagic cases are hard to diagnose; that histories of hemophilia, swollen joints, hematoma following injury, and continuous bleeding after cuts are seldom obtained. Hemorrhage from fibrous tonsils, the cicatricial tissue preventing collapse of the vessels, appears to be the most frequent cause. In anemic cases the lack of fibrin predisposes to hemorrhage and in some malignant cases it is as well to ligate the common carotid. Abnormalities in distribution of the ascending pharyngeal, tonsillar and internal carotid arteries are possible causes and where several large vessels pass from the pillars to the tonsils they should be divided by the electro-cautery, some days previous to the tonsillotomy.

As exciting causes traumatism of the pharyngeal pillar and the local action of cocain and adrenalin are mentioned and the latter depreciated.

After mentioning the galvano-cautery, local styptics and the purse string suture around the bleeding area, mechanical pressure by the tonsillar hemostat is described as "the sheet anchor of the throat surgeon and dissipates all fear as to possible fatal hemorrhage, except in hemophilia." The instrument of Mickulicz-Stoerk with detachable handles is the one advised, care being taken to avoid a slough from pressure. PERRY.

The Influence of Resection of the Cervical Sympathetic Ganglia in Glaucoma.—By William H. Wilder, M. D., Annals of Ophthalmology, January, 1904.

The author gives a detailed report of seven cases of sympathectomy for glaucoma occurring in his practice. In two cases of the chronic inflammatory type without benefit subsequent iridectomy was done with improvement in condition of the eyes. Five cases were for simple glaucoma, improvement occurring in two, while in the remaining cases no benefit resulted. In one of these cases an iridectomy was performed with questionable benefit. Little significance is given to the histologic findings in the excised ganglia.

He gives an abstract of the records of sixty-one cases of sympathectomy for glaucoma that have been done in this country. Thirty-eight cases were for simple glaucoma; sixteen for chronic inflammatory glaucoma; four for subacute glaucoma; three for acute glaucoma; four for absolute glaucoma; two for hemorrhagic glaucoma, and one for buphthalmus.

Five of these operations were preventive, no glaucoma appearing up to the time of the report. One death occurred, but this would have happened in almost any other operation on the neck. Twenty-six cases in the series were improved as a result of the operation; ten were temporarily improved; seven were stationary, and twenty-five were unimproved.

Myosis resulted in forty cases, and in most instances it seemed to be permanent; the tension was reduced to normal in thirty-four cases and lowered in nine. Ptosis on operated side was observed in thirty-six cases, but was not permanent, lasting from a few days to one year. Conjunctival congestion more or less transient in character was seen in nineteen cases. Neuralgia, hyperesthesia, anesthesia, hoarseness, aphonia dysphonia and dysphagia were some of the sequelae noted in various cases, though they usually lasted but a short time. The results obtained in this series of cases are not as favorable as those given by Robmer.

The author states that positive conclusions as to the merits of the operation are not yet to be reached; that the operation is not to be too hastily condemned. If it is to be compared to iridectomy it should be given an early trial in any form of the disease in which it is applicable. Statistics seem to indicate that the simple chronic form is the one most suited for sympathectomy. As a guide in his own practice he states that he should feel very much like following the advice of Abadee: "In acute forms of glaucoma and in subacute intermissions practice iridectomy first and if it fails do sympathectomy. In simple glaucoma use myotics twice a day; if they suffice continue them; if, in spite of their systematic use, vision fails, do sympathectomy."

HAWLEY.

BOOK REVIEWS.

Edited by

KENELM WINSLOW, M. D.

International Clinics.—Volume 1. Fourteenth Series, 1904. J. B. Lippincott Company; 304 pp. $2.00.

This well-known quarterly it is again our pleasure to review. The present number is remarkably rich in illustrations and contains valuable articles. The work opens with an interesting paper by Widal and Juval on experimental clinical observations on the effect of sodium chloride in nephritis which have already attracted the attention of the whole medical profession. By excluding salt from the diet of patients withe chronic nephritis it was found that both edema and albuminuria were correspondingly reduced. When salt was freely given it accumulated in the system and seemed to cause hydration of the tissues, with gain in weight and edema, but on being then withheld the salt was eliminated with dehydration of the body and loss of anasarca.

The uses of collargol are set forth by Netter and Salmon of Paris. The effects of soluble metallic silver in septic conditions are still somewhat sub judice, but many remarkable recoveries have been reported during the last five years following the use of this remedy. The reviewer has recently seen a purulent pyelitis of unknown origin with hectic fever respond almost instantaneously to collargol inunctions, so that the temperature fell to normal and remained so thereafter within twelve hours of using the treatment and in the tenth day of the disease. Two to three grams of Crede's ointment, or 20 to 30 mgms. of collargol in 1 to 2 per cent. watery solution may be used twice daily, the first by inunction; the last by intravenous injection with perfect safety. In the Johns Hopkins Bull. for Feb., 1904, may be found reports of the use of silver nitrate given intravenously for a great variety of pyogenic and streptococcic infections with what speakers at meetings of the Johns Hopkins Medical Society called "startling and marvelous" results. In these cases .5 cc. of a 10 per cent. solution of silver nitrate was added to 500 cc. of sterile water and injected into a vein at 110° to 115° F. Patients apparently dying of purulent peritonitis and other septic conditions were apparently rescued from the grave by this treatment.

Favill, of Chicago, reports some cases of nephritis following or accompanying attacks of acute indigestion, many of which made complete recoveries. Edes, of Boston, shows much of his usual wisdom in his remarks on the cure of neurasthenia. Cattel, of Philadelphia, writes on the application of cryoscopy and explains thoroughly the use of necessary apparatus with the help of an illustration. There is a very practical article by Walsh of New York on early diagnosis of pulmonary tuberculosis. Prolonged expiration, limitation of the excursions of the diaphragm on one side and cough; or simply loss of weight and cough; or loss of weight with a tendency to rapidity of the pulse at certain times a day and a temperature rising 1½ degrees above normal during the 24 hours—are, one or all, sufficient to make a probable diagnosis of consumption. John G. Clark reviews the methods of intestinal anastomosis and concludes that the "Connell suture is without doubt the most rapid and perfect method of suture yet devised for end-to-end or lateral anastomosis" (illustrated). Carl Beck considers exhaustively angioma in a well-illustrated paper. Davenport and Craig of Boston write on the non-operative treatment of diseases of the female generative tract in a fair and unprejudiced spirit. Space does not permit of attention to the sections on Progress of Medicine, Surgery or Treatment, further than to note that Bloodgood is editing the surgery section which he has done so acceptably in the past for Progressive Medicine. Altogether we note constant improvement in this publication; there is less and less of the commonplace student's clinical lecture and more and more attention is given to originality and progress of medicine. It is an unusually good number.

number.

WINSLOW.

The Medical News Pocket Formulary. By E. Quin Thornton, M. D., Assistant Professor of Materia Medica in the Jefferson Medical College, Philadelphia. New (sixth) edition. Leather, wallet shape for the pocket, $1.50, net. Lea Brothers & Co., Philadelphia and New York, 1904.

This popular work, which has run through six editions, consists of a condensed treatise on treatment, chiefly in the form of prescriptions. For easy reference, diseases are arranged alphabetically. While the competent physician has an innate suspicion of such short-hand methods to success in practice, yet on close inspection the work is an eminently worthy one. The latest remedies are to be found, and wise discrimination has been used in the annotations and indications to guide the physician in the choice of formulae. The book will prove of especial value for the country physician who is hurried and often far away from books of reference on his rounds, and he will feel it a great comfort to carry such a pocket remembrancer containing hints of the most approved modern practice. To the physician in office-practice, the book will also be of much service if kept on the desk for instant reference. In appearance it looks like a memorandum book and if consulted in the patient's presence will not give the impression that his case is being studied. The physician is expected to prescribe off-hand from his mental store, whereas the lawyer often refuses to consider a case until he consults the authorities. This is a foolish prejudice and one which works to the detriment of the patient. The reviewer has in mind one of the most generally-able, country practitioners it has been his good fortune to know, who habitually studied peculiar cases (especially those coming from remote parts who could not be seen frequently) in his office by consulting the authorities on the subject in the presence of the patient and with no lessening of his own influence. To give a concrete example out of the book, we see under pyemia and septicemia the following: Streptococcus serum with dosage and diseases in which it may be useful (we note no reference to its use in scarlet fever). A prescription for oil of turpentine then follows, and dosage and uses of streptolytic serum. Next comes a prescription for tinc. ferri chloridi, and one for the intravenous injection of collargol with directions and indications for its employment, and also for the external use of unguentum Crede. It will be seen that the work is well up to date. In the beginning may be found dose-tables and a section on poisons and antidotes. The book is bound in flexible leather of a size to be carried conveniently in the pocket. WINSLOW.

Manual of Materia Medica and Pharmacy. Specially designed for the use of practitioners and medical, pharmaceutical, dental and veterinary students. By E. Stanton Muir, Ph. G., V. M. D. Instructor in Comparative Materia Medica and Pharmacy in the University of Pennsylvania, Third edition, revised and enlarged. Crown octavo, 192 pages, interleaved throughout. Bound in extra cloth, $2.00 net. F. A. Davis Company, publishers, 1914-16 Cherry street, Philadelphia.

Dr. Muir's book is a model of its kind. It is ideal for students of materia medica and pharmacy in its clearness, conciseness, and freedom from all superfluous details, besides being interleaved throughout for purposes of note-taking. The volume—as our readers will remember is so familiarly described in the opening lines of Caesar—like all Gaul "in tres partes divisa est". The first part is devoted to definitions and a brief account of botanical terms which are used in the description of the vegetable drugs. Here is the only error which we detected in the book—on page 12 phyllotaxis is incorrectly spelled "phylotaxis". In the second part are considered individual drugs, including a description of their source, physical properties, preparations, therapeutic actions as denoted by single words (cathartic, rubefacient, etc.,) and a novel feature—doses for man and the domestic animals. The third part is given up to pharmacy and in it may be found a description of all the pharmaceutical processes and of the various preparations used in medicine. The book is printed in good clear type, on heavy paper, is neatly bound in blue cloth and reflects credit alike on author and publisher. WINSLOW.

REPORT OF CONTAGIOUS DISEASES.

TO THE WASHINGTON STATE BOARD OF HEALTH FOR APRIL, 1904.

	Smallpox		Scarlet Fever		Diphtheria		Typhoid Fever	
Counties.	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*
Adams	3	0	18	0	0	0	1	0
Chehalis	0	0	1	0	0	0	3	0
Chelan	5	0	2	0	13	1	0	0
Columbia	0	0	0	0	3	0	0	0
Cowlitz	0	0	0	0	0	0	1	0
Douglas	0	0	0	0	9	3	0	0
Jefferson	1	0	1	0	0	0	0	0
King	6	0	16	0	11	2	0	0
Kitsap	0	0	18	0	7	3	0	0
Kittitas	0	0	0	0	1	0	0	0
Klickitat	7	0	0	0	0	0	0	0
Lincoln	1	0	3	0	0	0	0	0
Spokane	0	0	5	0	1	0	0	0
Walla Walla	0	0	1	0	1	0	0	0
Whatcom	0	0	1	1	0	0	0	0
Whitman	0	0	1	0	8	1	0	0
Yakima	1	0	5	1	5	2	0	0
Seattle (city)	22	0	42	1	32	6	7	5
Spokane (city)	4	0	5	0	10	0	0	3
Tacoma (city)	0	0	3	0	2	0	5	2
Total	50	0	122	3	106	18	17	10
Total April, 1903	202	0	30	5	25	3	..	..
Total 1904	182	1	556	23	404	56	183	48
Same period, 1903	471	0	307	5	71	3	..	..

ELMER E. HEG, Secretary.

MEDICAL SOCIETIES.

Name. Meetings Held.

Washington State Medical Association.........July 12, 13, 14—Seattle
President, F. H. Coe, M. D.; Secretary, A. H. Coe, M. D.

Chehalis County Society ....Second Tuesday—Aberdeen
President, D. A. Schumacher, M. D.; Secretary, J. W. Scamell, M. D.

Chelan County Medical Society..............................
President, W. M. McCoy, M. D.; Secretary, H. A. Saunders, M. D.

King County Society ....First and Third Monday—Seattle
President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

Pacific County Society ....
............Third Monday of Jan., April, July, Oct.—South Bend
President, G. W. Overmeyer, M. D.; Secretary, Mary W. Gunwell, M. D.

Pierce County Society.............First and Third Tuesday—Tacoma
President, C. Quevli, M. D., Secretary, A. de Y. Green, M. D.

Skagit County Society ....
President, A. C. Lewis, M. D.; Secretary, R. J. Cassel, M. D.

Snohomish County Society..................First Tuesday—Everett
President, C. A. Mead, M. D.; Secretary, James Chisholm, M. D.

Spokane County Society...................First Thursday—Spokane
President, G. S. Armstrong, M. D.; Secretary, Geo. A. Gray, M. D.

Walla Walla County Society.........Second Wednesday—Walla Walla
President, N. G. Blalock, M. D.; Secretary, Y. C. Blalock, M. D.

Whatcom County Society.................Second Monday—Whatcom
President, D. E. Biggs, M. D.; Secretary, W. N. Hunt, M. D.

Whitman County Socity.........Third Monday of Jan., Apr., July, Oct.
President, W. N. Divine, M. D.; Secretary, R. J. Skaife.

Yakima County Society..............First Tuesday—North Yakima
President, David Rosser, M. D.; Secretary, Carver, M. D.

Oregon State Medical Association.....................1904—Portland
President, W. T. Williamson, M. D.; Secretary, L. H. Hamilton, M. D.

City and County Medical Society of Portland...First Wed.—Portland
President, R. L. Gillespie, M. D.; Secretary, A. D. Mackenzie, M. D.

Multnomah County Medical Society..........First Tuesday—Portland
President, A. Tilzer, M. D.; Secretary, L. Victoria Hampton, M. D.

Montana State Medical Association 1905
President, B. C. Brooke, M. D.; Secretary, Grace W. Cahoon, M. D.

Silver Bow Medical Society....Second and Fourth Wednesdays—Butte
President, T. J. Murray, M. D.; Secretary, Grace W. Cahoon, M. D.

Idaho State Medical Association............October 6 and 7—Lewiston
President, J. L. Conant, Jr.; Secretary, E. E. Maxey, M. D.

North Idaho District Medical Society..............June 9—Lewiston
President, C. L. Gritman, M. D.; Secretary, C. D. Parsons, M. D.

South Idaho District Medical Society............July 2—Idaho Falls
President, H. A. Castle, M. D.; Secretary, E. W. Kleinman, M. D.

Canadian Medical Association............Aug. 23, 24, 25—Vancouver

British Columbia Medical Association..............1904—Vancouver
President, A. P. Procter, M. D.; Secretary, W. D. Brydone-Jack, M. D.

Vancouver Medical Society ....Vancouver
President, W. D. Brydone-Jack, M. D.; Secretary, J. S. Conklin, M. D.

Corrections and additions to this list are requested from societies reached by this journal.

NORTHWEST MEDICINE

July, 1904.

ORIGINAL CONTRIBUTIONS.

THE INCREASE OF INSANITY AND ITS REMEDY.*

By J. B. Loughary, M. D.,
SEATTLE, WASH.
Late resident physician, Western Washington Hospital for the Insane.

For centuries past mental unsoundness has been a subject of profound interest to every student of psychology. Of late years, however, it has not only commanded the attention of our taxpayers, whose duty it is to care for our indigent insane, but also that of the thinking class, the humane, God-loving class of people, whose hands are always open to the unfortunate, no matter whether they be sane or insane. The fact that insanity is increasing from year to year makes the subject all the more important, particularly from a prophylactic standpoint. It falls upon us, therefore, as citizens and taxpayers, to see to it that the insane of this state are receiving all that they are entitled to.

There is nothing that appeals to our sympathies and love more than the unfortunate individuals who have been deprived of their reason. This is particularly true when they have become the care of the county or the state in which they live. The man who is crippled by accident or otherwise deserves the sympathy of every one. The woman who is left in this world to struggle for herself and her loved ones, without assistance or financial aid, is to be pitied; or again, the child who is left without father or mother, without a friend or relative, demands our love and support; but to me this is nothing compared to the thousand upon thousand of individuals whose intellects have been shattered by disease and are left by the wayside to suffer and at last drift into terminal dementia and death.

A very eminent specialist, in the State of Indiana, gives us a warning in regard to the increase of mental disease, by saying, that in his opinion the "entire world is going mad."

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*Read before the Conference of Charities and Corrections, Seattle, Wash., Feb. 2-4, 1904.

Dr. Hoyt, whose observation we cannot ignore, in speaking of the alarming increase in lunacy, says: That in about 200 years more, at the present rate, the entire civilized world will be fit subjects for insane asylums. Such opinions as these may be regarded as those of extremists or those who are sounding an unnecessary alarm. Be that as it may, it tends to show the interest taken in this subject by psychologists and also to show a gradual and, I may say, an alarming increase in mental as well as nervous diseases within the last half century.

In proof of what I have said, let me cite a few statistics. They are not, of course, absolutely correct, but sufficiently so, I trust, for all practical purposes. According to a late report of the Lunacy Commission of England and Wales, the number of insane in the year 1859 was 36,762, or a proportion to population of 1 in 536. In January, 1903 (44 years), the number had increased to 113,964, or a proportion to population of 1 in every 293. The number of people who lost their minds in the year 1902 alone, throughout England and Wales, was 22,581, or about 500 per week. This is about three every hour, day and night. Does this not show an alarming condition?

Let us take a few figures in our own country. Dr. Fletcher, of the State of Indiana, says that 50 or 100 years ago it was rare to hear of a case of lunacy. Now it is almost a daily occurrence. At that time there was but one case of insanity to every 1,500 of population. Today there is one in every 400, and each census shows a gradual increase throughout the entire land. In this connection Dr. Fletcher says there must be more attention paid to the developing of "brawn and brain," stricter marriage laws and fewer fads in schools. He believes no one should be allowed to marry unless he or she can take a physical and mental examination and prove himself thoroughly fit.

Dr. A. B. Hays, of the State Insane Asylum of Jackson, Louisiana, gives us a warning about the increase of lunacy. He says the insane had doubled in his state in the last six or seven years, which is at the rate of about 10 per cent. per annum, being four times as fast as the increase in the population. He also says that, in his opinion, if something is not done to check the rapid growth the care of the insane will become a great burden to the state.

In the State Insane Asylum of Oregon, in the year 1883, the earliest date of which we have any record, there were 268 males and 102 females, or a total of 370. This is a proportion to population of 1 in 500. In 1893, ten years later, there were 614 males and 279 females, a total of 893, or a proportion to population of 1 in 375. In 1903, twenty years later, there were 903 males and 391 females, or a total of 1,294, giving a proportion to the population of 1 in 342.

In the State of Idaho there were, as near as I can determine, 25 patients under the state charge in 1880, which is a proportion to population of about 1 in 1,300. In 1890, ten years later, there were 64 insane subjects, or a proportion to population of 1 in 1,317, a slight decrease, if you notice. In 1900, twenty years later, there were 209 inmates, or a proportion to population of 1 in 769.

In the State of Washington in the year 1870, there were 32 patients under the state charge, or a proportion to population of 1 in 747. In 1880, ten years later, there were 108 inmates, or a proportion to population of 1 in 695. In the year 1890, twenty years later, there were in the Western Washington Hospital 561 inmates, and in the Eastern Hospital 140, or a total of 701, giving as a proportion to population of 1 in 484. In 1900 we had, in the Western Hospital, 825 inmates, and in the Eastern Hospital 436, giving as a total of 1,261, or a proportion to the population of 1 in 402.

I have not secured data of other states, but I am certain they are about the same and show a gradual increase from year to year. Dr. Robt. Jones, in an address before the British Medical Association, dwells upon the great increase of insanity, and the necessity of certain measures of checking its progress. He says that nervous diseases are increasing out of proportion to other maladies. The disease known as Paresis, or General Paralysis of the insane, which is one of the most highly evolved forms of mental deterioration, occurring as it does mainly in persons of great intellectual power, was discovered less than one hundred years ago in Great Britain. Today, 21.7 per cent. of the males admitted into the London Asylum and 6.7 per cent. of females are suffering from this type of insanity. Again, insanity seems to be of a more severe form today than it was years ago. A century or more ago it was more of the maniacal type, whereas today it tends more towards melancholia. Recovery from melancholia is rarer than in most forms of mania. Statistics centuries ago show that 60 to 70 per cent. of all cases of insanity recovered; today the rate of recoveries has fallen to about 38 to 40 per cent., notwithstanding all the scientific progress and therapeutic aid placed at the disposal of the physician.

The pressure of civilization; the struggle to attain the almighty dollar: the increase of certain forms of nervous diseases: the increase of the use of alcoholic liquors, which are more or less adulterated: the strain of the mental functions in our school and every day life at the expense of the physical, are some of the many exciting causes of the increasing mental bankruptcy which exists at the present time.

I think I have said enough to demonstrate the necessity of something being done to check this rapid growth. The next thing is, what are we going to offer as a remedy for this alarming condition? What can we suggest that will be accepted willingly, and at the same time prove satisfactory?

The first thing which suggests itself to me is *Education.*

The second is *Co-operation* on the part of the people.

The third is *Legislation.*

Under the head of education I would inisist upon educating ourselves and our children to pay more attention to the development of the *physical* system and not so much the *mental.*

Educate ourselves to live slower, eat and sleep more, drink and dissipate less.

Educate ourselves to regard our insane people with the same respect, the same love and sympathy as our sane people. Take the same interest in our hospital for the insane, as for the sane, and having done this, we not only prevent in a way the spread of disease, but we have overcome one of the greatest obstacles, have neutralized a superstition and prejudice existing among the people relative to the state institutions for the insane. I believe I am safe in saying that we are today twenty-five years behind the times in the esteem in which we regard our state hospitals; they are today viewed with more suspicion, more projudice and tradition than any other institutions in the land. For instance, twenty-five years ago the thought of going to a fever hospital to be treated for a fever, or a surgical hospital for an operation or a lying-in hospital to be confined, was looked upon with the same fear and doubt that is now entertained towards a lunatic asylum. It was like taking ones life into his own hands to enter such institutions and if one came out alive it was attributed largely to the all wise hands of Providence. Today almost every one, apparently, is koncking at the doors of our sick hospitals for admittance. It matters not whether it be a simple cold or a severe surgical operationfi we have learned by experience, which is education, that such institutions are not death traps but homes, where we are surrounded by the best of medical skill and are nursed by experienced hands.

What, may I ask, is the custom or unwritten law when the same individual is stricken with a mental ailment? Is he or she taken to a hospital in an ambulance, guarded by a trained nurse? Do you find people knocking on the door of our state asylums for admittance? On the contrary, they look upon it as a stigma, a disgrace, as a sin for which they must suffer, and the least said about it the better.

Why, I want to ask, is it any more a disgrace to be afflicted with a mental than a physical disease? There is none other than what I have mentioned—superstition and lack of proper education.

The second remedy is co-operation. Without a certain amount of co-operation on the part of the people, it is difficult or impossible to get legislation, therefore, to get in close touch with state institutions. Visit them oftener, get acquainted with the officers and employees. Find out the wants and demands of these unfortunate individuals, and when this is done, we will be in a better position to formulate laws governing state institutions and also to demand adequate appropriations for their maintenance.

Under the head of *legislation* I want to call attention in the first place to strict marriage laws. Create an examining board of capable medical men and require every person to undergo an examination, both physical and mental, and prove himself fit before he be allowed to enter into marriage contract; for it is shown by statistics, that 60 to 75 per cent. of all cases of insanity are due to heredity. If this be true, then there must be something radically wrong with the custom governing marriages.

Dr. Rentoul agrees with army medical examiners and the numerous private practitioners who have insisted for some time that the physical standard of the British race is degenerating, and by applying the ancient maxim of the connection between a healthy mind and a healthy body, claims foundation for his reasoning on the latest statistics. In England and Wales one person in every 301 is an officially notified lunatic, while in Scotland and Ireland the percentages are, respectively, one in 247 and 206. The records show that in 1901 nearly a fourth of those who applied for army enlistment were rejected as physically unfit, while more than 1000 more were discharged for this reason within three months after their enrollment.

This physician also believes that something should be done, and in a hurry, to control the marriages of persons discharged from asylums. In support of his contention, he points out that from 1885 to 1903, 8,933 lunatics were discharged from asylums in this country as "recovered", and that 2,285 of them had to be readmitted. He mentions one case of a man who was discharged from an asylum, and who within a few months married the daughter of a woman who had been in the same asylum for years. Another case instanced is that of a man, "dull and partially idiotic", who married a woman more than half idiotic. They had nine children, all idiots.

If 60 to 75 per cent. of all cases of insanity are due to heredity, as I have already said, then the practical effect of such a law is apparent.

I agree with Dr. Fletcher, that no one who has the germs of insanity in his system for generations back or has the nervous instability which superinduces nervous and mental disease, has any moral right, nor should he have any legal right to enter into the marriage contract, and thus bring nervous wrecks and mental degenerates into this world, only to become a burden to the state in which they live. As a result of this influence, we are today, so I am told, caring for over 200 inmates of different institutions, who are not even citizens of the United States.

Under the head of legislation, I want to refer to the pernicious effect of politics in the management of our state institutions.

I think I am safe in saying that nine-tenths of the inefficiency charged against the management of lunatic asylums, are due directly or indirectly to politics. Nine-tenths of the scandals emanating from state hospitals and penitentiaries result from disappointed office holders; therefore, eliminate political influences from state institutions of all kinds. Let the motto be, skill and experience both with officers and employee, regardless of political affiliation or religious faith. Employ men and women who are adapted to fill the positions and not those who controlled the greater number of votes at the last election. In other words, "select the man for the place, and not the place for the man."

Place our institutions under civil service or any other system that will give protection to the mentally afflicted. Let the officers and employes be not politicians, but men and women with efficiency, experience, love and sympathy for those who are under their charge and when this is done, we have accomplished one of the greatest blessings to humanity, as well as to the mental deteriorates who are sent there for treatment.

I desire also to call attention to our present law governing the examination and commitment of the insane. While the laws of the State of Washington are very much the same as all other states, nevertheless, as a matter of humanity, certain changes should be made.

When one's mental condition is put in question, our present law requires a complaint to be sworn to before the county clerk, declaring him to be insane and unsafe to be at large. This complaint is then placed in the hands of the sheriff, who immediately places him under arrest and, in a large majority of cases, confined in the county jail in company with murderers, hoboes, in fact, all kinds of criminals, there to remain for 12 to 72 hours, until the judge can find time for hearing. During all this time he is without medical aid or the attention of a nurse. If such treatment does not tend to hasten, instead of checking mental confusion, I do not know of anything that will.

I question also the propriety as well as the humanity of conducting a medical examination before a legal tribunal in open court. Does not that strike one as being unjust or inhuman? There is a universal law prohibiting family or professional secrets being divulged on the witness stand, but in mental examinations which are made before a legal hearing, family histories, private matters and secrets are drawn out in open court, where hangers on about a court room are ready to take up and comment on them as they see fit. Why make this a legal hearing, when it is in reality purely and solely a medical one. The examinations are as a rule made very hurriedly and at times by inexperienced boards, as will be seen by glancing over the commitment papers.

I would offer as a substitute for this custom, that there be appointed by the governor, a Board of Examiners of medical men, who shall have power to take charge of the insane and dispose of them as seems in their judgment proper. Let this be a *medical,* instead of a *legal* court. The case might be one which requires treatment in a hospital. It might be one which properly belongs to a county alms-house, and thus would avoid the stigma of a commitment to an asylum. This one thing alone, it seems to me, is sufficient to commend this system to any person who will stop a moment to consider.

When we come to regard the insane person with the same love and respect that we do the sane, then that fear and superstition relative to lunatic asylums will vanish; more than that, the percentage of recoveries will increase and death rate decrease, while a happier, healthier and more humane spirit will exist throughout the land.

TYPHOID FEVER, ETIOLOGY AND PATHOLOGY.*

By H. G. Lazelle, M. D.,
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The micro-organism of typhoid fever was discovered by Eberth in 1880, and a little later was isolated and grown in pure culture by Gaffky. This germ, called bacillus typhosus, is a short thick rod with rounded ends, about three times as long as thick, its length being about one-third the diameter of a red blood cell. It varies much in appearance under different conditions, often forming threads or filmaments by the arrangement of the rods end to end. It is actively motile, possessing many flagella, and is non-spore forming. It is both saprophytic and parasitic, enjoys strong resisting powers, accommodating itself to its environment better than many other pathogenic bacteria. It has been found in air, water, milk, dust, sewage, clothing, flies, oysters, and other material. It can be frozen and thawed without apparent injury and its thermal death point, according to Sternberg, is 60° C.

Exposure to strong sunlight injures cultures and the bacilli are killed after ten hours of such exposure. It has retained its vitality for three months in distilled water, 60 to 70 days upon linen, and is not killed by carbolic acid in strengths of one-tenth to two-tenths per cent. It grows well and characteristically on culture media, is readily stained by analin dyes but loses color when stained by Gram's method. It fulfills two requirements of Koch's law, but the reproduction of distinct typhoid in animals by inoculation has not been altogether successful, though recent claims have been made to this effect. It produces a toxin and one of its interesting as well as important characteristics is its agglutination by typhoid blood or serum. The bacillus typhosus closely resembles the colon bacillus and its group normally present (soon after birth) in the intestinal tract, the paratyphoid bacillus and several other pathologic bacteria which may inhabit this region.

Typhoid fever is a disease of youth and young adults, the greater number of cases occurring between the ages of 15 to 25 years, It occurs, though infrequently, in persons under two and over 50 years of age; even the fetus does not escape. Sex has no influence. Rich and poor alike are afflicted, though poor hygiene may increase susceptibility. Locality has no important bearing except as regards drainage and water supply.

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Certain individuals apparently possess natural immunity and those recovering from the disease are immune for a number of years, though recurrences are frequent later in life. One author states that the Chinese in Hong Kong appear to be immune to typhoid fever.

Recently attempts have been made in the British army, with some apparent successs, to establish artificial immunity by inoculating with lysolized cultures of typhoid bacilli.

As to seasons, the most prevalent time for the disease is during the last six months of the year, especially the autumn months. Serious epidemics have however occurred during the spring months, through infection of the water supply. Low ground water during hot weather, some consider an agent in spreading the disease.

Since the discovery of the organism of typhoid fever much research work has been done to establish the means of its entrance into the system, and it is now quite clear that this is through ingestion, though rarely it may be inhaled and gain the circulation through the respiratory tract or lymphatics. Infected drinking water is one of the most common sources of typhoid fever outbreaks, the recent severe epidemic at Butler, Pa., being a sad illustration. Ice may also be a means of carrying the infection, as proved by Hutchings and Wheeler at Ogdensburg, N. Y.

The placing of municipal water supplies under the control of Boards of Health has effected a reduction in typhoid epidemics; but in rural districts there yet remains much work to eliminate this source of danger of infection of drinking water. Milk is another means of carrying the germs. Either the milk itself may be infected in its handling or the cans contaminated by washing them in impure water. Cases of typhoid fever have been traced to infected butter.

Edible shellfish, especially oysters, have been the cause of the disease. Oyster beds may be contaminated by sewage or the oysters infected by their removal to small streams and brackish waters where sewage abounds, for the purpose of fattening them. The secretions of the oyster furnish a favorable soil for the maintenance of the bacilli and these have been found in the shells of oysters seventeen days after the removal of the oysters from the water.

Flies are a source of dissemination of typhoid bacilli, not only by carrying them on their feet from place to place, but by feeding on infected material and discharging the bacilli in their feces. Experiments in feeding flies on typhoid bacilli have shown that for 23 days thereafter they would infect objects on which they alighted. When we consider the prevalence of open privy vaults in many districts it is not hard to understand how flies may be the distributors of germs over a large area from a single case of typhoid fever where disinfection is neglected.

Infected clothing has been known to be the cause of contracting this disease. One author states that in Africa violent wind and sand storms are a means of scattering typhoid germs and infecting food. Bacilli may enter the system through the ingestion of uncooked fruit or vegetables infected from the soil or by polluted water.

Every case of typhoid fever is a constant menace to a community unless thorough destruction of all bacilli emanating from the patient is accomplished. Bacilli have been demonstrated in the urine, fecal discharges, sputum and vomited matter of typhoid fever patients, and may in addition possibly be given off in exhalations from the lungs.

In many cases the urine remains infected with the germs for many days after the active period of the disease, hence the urine of convalescent cases should receive necessary disinfection (a point often overlooked), as it is a greater source of danger than the fecal discharges.

The danger of polluting streams and scattering typhoid germs by the present system of water closets in use on railroad trains has been of late appearing in the journals and is certainly of sufficient importance to receive vigorous attention.

Nothing more than a very brief consideration of the pathology of typhoid fever will be attempted in this paper. The recent work of Mallory and Councilman has probably given us a truer picture of the distinct and typical lesions of typhoid than we previously had.

The characteristic lesions occur in the intestinal lymph nodes, spleen, mesenteric glands, brain, bone marrow and sometimes kidney and other structures, and are produced by a soluble toxin causing a proliferation of the endothelial cells which become very phagocytic in character.

The changes in the intestines are usually considered as passing through four stages: first, hyperplasia and swelling of the intestinal nodes and messenteric glands; second, necrosis and sloughing; third, ulceration, and fourth, healing. During the first ten days to two weeks there is a catarrhal condition of the intestines with swelling of the lymphoid tissue. This swelling is greatest just above the ileo-cecal valve; the cecum and colon are affected in about one-third of all cases. Peyer's patches project above the general level and may measure from three to ten mm. in thickness. The swelling is due to the proliferation of the endothelial cells of the structure. These are very phagocytic and incorporate lymph cells, leucocytes and red blood cells. This leads to intense congestion with occlusion of vessels. Resolution of the node may take place at the end of two weeks by degeneration and absorption, but usually there is necrosis in larger or smaller areas. The necrotic tissue or slough is generally cast off in a mass, leaving a ragged ulcer with steep or overhanging edges. The erosion of a vessel may cause hemorrhage at this time. The floor of the ulcer is usually the submucosa, though it may reach to the muscularis or even serous coat, when perforation may occur. Necrosis in a Peyer's patch frequently occurs in different areas, so that a typical ovoid ulcer opposite the mesentery is not so often seen. The ulcerations in the solitary follicles are round.

Healing takes place by the formation of granulation tissue, while the epithelium regenerates from the ulcer's margin.

The lesion in the mesenteric glands is similar to that occurring in the lymph follicles of the intestine. We find hyperplasia of then endothelial cells lining the lymph sinuses and reticulum, with congestion, followed by resolution or necrosis with extensive fibrin formation.

The spleen is enlarged, soft, smooth and dusk red on section. There is hyperplasia with hyperemia. The endothelial cells lining the blood spaces proliferate and are phagocytic, containing many red blood cells, some leucocytes and plasma cells. From the congestion and occlusion of vessels by these proliferated cells infarcts may occur.

In a great many cases focal lesions occur in the liver and often in great numbers. They appear as greyish or yellowish specks, being chiefly found in the middle and peripheral zones of the lobules. These lesions in the liver arise from the endothelial cells which have proliferated in the lymphoid tissue of the intestine and spleen, been carried to the liver in the blood stream (portal circulation), and being large enough to block up the capillaries, cause miliary infarcts. The liver cells in these areas, as well as the transported phagocytic cells, undergo necrosis with fibrin formation.

The lesions in the bone marrow closely resemble those occurring in the spleen.

Rarely focal lesions have been found in the heart, kidneys, adrenals and testicles, but their nature is not clearly understood. In addition to these typhoid lesions of typhoid fever, through the action of the toxin or the bacilli in the blood stream, many changes may take place in the various organs or structures which entirely alter the picture and symptoms, but those lesions found in typhoid, which are also common to other infectious and wasting diseases, cannot be considered in this short outline. The blood in typhoid fever shows a condition of anemia and leucopenia.

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TYPHOID FEVER, DIAGNOSIS AND PROGNOSIS.*

By Robert M. Stith, M. D.,
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Perhaps no one of the common infectious diseases is so frequently mistaken as typhoid fever. In the rare and atypical cases it is not surprising, but that mistakes occur in diagnosing pure uncomplicated typhoid, is a reflection on the diagnostic ability of the professsion. Osler says, "Let the cock-sure physician who never makes mistakes read the report of the U. S. Army Commission on typhoid fever in the Spanish-American war." The substance of that report is somewhat as follows: That of every one hundred cases of typhoid fever sent to the division hospitals, one-half had escaped the diagnosis of the regimental surgeons and these were cases of pure uncomplicated typhoid. The commission also reported that there were no fatal malarial infections among the soldiers in any part of the United States; but, according to the Census Bureau, the profession of the United States says that for every seven deaths due to typhoid, three die of malaria. This mistaking typhoid for malaria, and calling it typho-malaria seems to be quite common in some parts of our country.

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It is unfortunate, as Herrick says, that our commonest continued fever, typhoid, should imitate other infections and that other infections should imitate typhoid.

Before the New York Academy, J. P. Crozier Griffith recently stated that in the Children's Hospital, Philadelphia, the cases of typhoid constantly outnumbered those of any other single disease. New York pediatrists remarked that they seldom saw typhoid in children, although the children of the metropolis frequently suffered from an obscure fever which one distinguished clinician named "New York Fever." This reminds one strongly of cases that occurred along Six Mile Creek in a certain section of our country and were, for a long time, called Ithaca Fever.

Osler says typhoid is extremely variable in its manifestations and that even under the best conditions mistakes are inevitable. The clinical picture will vary with the intensity of infection, the resistance and age of the patient, the organ or organs bearing the brunt of the attack and the sanitary surroundings. Often, when beginning with symptoms of bronchitis or pneumonia, the diagnosis is not made, and the careless physician will think that he is under the necessity of explaining how the bronchitis or pneumonia has run into typhoid. While bronchitis or pneumonia may be co-incident with typhoid, they are often among its primary symptoms.

Typhoid beginning with meningeal symptoms is often mistaken for cerebro-spinal meningitis. Pneumonia, malaria, certain forms of pyemia, acute miliary tuberculosis, acute ulcerative endocarditis, cerebro-spinal meningitis and in children, catarrhal enteritis, most frequently give rise to mistakes. Less commonly, tubercular peritonitis, appendicitis, influenza (gastro-intestinal form), tubercular meningitis, trichiniasis, typhus, and malta fevers.

A FEW POINTS IN DIFFERENTIAL DIAGNOSIS.

Pneumonia.—Sudden onset, chill, high leucocyte count, absence of Widal reaction, herpes labialis often present.

Malaria.—The presence of the plasmodium, absence of Widal. Also, presence of herpes.

Acute endocarditis (Typhoid in type).—Petechial and other rashes, high leucocyte count. Temperature curve more irregular. Cardiac pain, dyspnea.

Cerebro-spinal meningitis.—The presence of Kernig's sign, high leucocytes. Examination of the fluid obtained by lumbar puncture shows the diplococcus intra-cellularis.

Military tuberculosis.—Rarely nose bleed, pulse rarely dicrotic, often rapid in proportion to temperature. Widal negative. Rose spots occur but not in successsive crops. Eyes may show choroidal tubercles. Fluid obtained by lumbar puncture has shown tubercle bacilli in abundance. (Osler.)

Tubercular peritonitis.—Abdominal pain marked. Accumulation of fluid. Absence of Widal reaction.

Appendicitis.—Usually gives a marked increase in leucocytes. Widal, absent.

Tubercular meningitis.—Choroidal tubercles. Bacilli by lumbar puncture. Widal absent.

It is often impossible to make a diagnosis from symptoms alone, especially in the atypical cases. Here we expect the laboratory to help us.

And now a word about the specific reactions.

The Widal.—The Widal reaction, that is, the loss of motility and clumping of typhoid bacilli when brought in contact with typhoid blood serum in proper dilution (the higher dilutions alone are of value). Ninety-five per cent of all cases of typhoid fever show the Widal reaction at some time in their course, but the reaction, while usually occurring from the fifth to the tenth day, may be much delayed (Gwyn reports a case first positive on the forty-second day), and undoubted cases (because typhoid bacilli were demonstrated in the blood) may never give it. Not more than fifty per cent. will give the reaction when first seen.

The Widal reaction will usually persist three to four months; sometimes it has been present eight to ten years after an attack of typhoid fever. It may disappear during convalescence. Tyson says the test should be made every two days until positive or until satisfied it will not appear. This is obviously impossible except in hospital practice.

The Leucocytes.—They show a progressive diminution throughout an attack of uncomplicated typhoid. This is a valuable point in the differential diagnosis from diseases which show a high leucocyte count, as pneumonia, pyemia, acute ulcerative endocarditis, cerebro-spinal meningitis, etc.

The Diazo Reaction.—This occurs with great constancy and is of some diagnostic aid when considered in relation to other symptoms. This reaction occurs in other diseases. So, too, does enlargement of the spleen, nose-bleed, diarrhea, tympanitis, etc. The

Diazo reaction occurs in pneumonia, scarlet fever, measles, malaria, septic conditions, military tuberculosis and advanced malignant disease.

Ott says the discredit into which it has fallen is due to lack of proper precaution in technic. Chemicals must be pure, urine recent. There should have been no medication prior to the test. Color must be cherry red and most marked in the foam. Green, of St. Paul, says it is possible to get a Diazo reaction with any urine, if we have an excess of sodium nitrite. He recommends a dilution of the nitrite, 1-100 instead of 1-40, as commonly used, and claims urine or diseases which ordinarily give a positive reaction will be negative, while typhoid is positive.

Blood Cultures.—So far the earliest and surest way of diagnosing typhoid is by means of blood culture. Some of the blood is taken under aseptic precautions and a flask culture of bouillon made and incubated. Schottmueller, in Leonhartz' clinic, Hamburg, secured cultures from the blood of typhoid cases eighty-four times in one hundred and one cases. Positive results are obtained earlier than by the Widal test. As a general rule the bacilli were obtained in greater numbers in the more severe cases. In one case he obtained the cultures on the second day.

The bacillus is found in the feces later than in the blood, but with comparative ease, and is of value as a corroborative sign. So, too, with cultures taken from the rose spots, but at they appear about the eighth day it is no advantage.

Para-Colon or Para-Typhoid Infections.—Undoubtedly there exists a group of organisms which are intermediate in their biologic manifestations between the typhoid and colon bacilli. Whether these belong to the typhoid or colon group or in a division by themselves is not definitely determined. In fact, it seems there are two such groups, one more closely resembling the typhoid, the other the colon. They give rise to a clinical picture, including rose spots, that is indistinguishable from typhoid. The Widal reaction has been absent, but the blood serum would give an agglutination reaction with the para-colon bacilli.

Clinically the cases appear as mild typhoid. There are but five autopsies reported, and these show a total escape of Peyer's patches. We must remember, however, that undoubted cases of typhoid have occurred in which no intestinal lesions were found at autopsy.

Most cases of typhoid, in infancy and childhood, according to Griffith are of the ambulatory type. Vomiting is common during the onset and during the course. Rash commonly, but not universally present. In some cases very abundant, covering entire integument. Course is shorter, averaging seventeen days; diarrhea less frequent. Tympanitis and hemorrhage are less common. Nervous phenomena are marked. The most common mistakes are to diagnose meningitis or catarrhal enteritis.

Prognosis in typhoid fever is always uncertain. Unfavorable symptoms are:

High teperature, marked toxic symptoms, muttering delirium, hemorrhage, extreme tympany, perforation.

In Tyson's experience the ambulatory type has always been fatal. Fat people and those beyond middle life stand typhoid badly. The mortality under the Brand method of treatment is about 7 per cent.; children, (Griffith) 3 per cent.

TREATMENT OF TYPHOID FEVER.*

By Elmer E. Heg. M. D.,
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Since 1889 I have had the privilege of seeing and following throughout the larger part of the course of the disease, or have personally treated, about 1500 cases of typhoid fever, and it is of the deductions made from this experience that I shall mainly confine my remarks upon the treatment of typhoid.

In treating a typhoid fever case we must consider the patient and all that pertains to him physically and mentally, the length of the disease, the severity of the symptoms and the possible complications. If we could abort the disease, and so shorten its course, we would be justified in using reasonably heroic measures to do so, but, considering the etiology and pathology and the fact that we almost never see a case until the middle or end of the first week, by which time the bacilli are snugly buried and multiplying beneath the surface of the intestinal mucous membrane, such an effort, with the means now at hand, is certainly foreordained to failure. Any remedy, given by way of alimentary tract, that would destroy or remove or even diminish the bacilli in sufficient quantity to abort or materially shorten the duration of the disease, would far more surely injure or destroy the patient. Yet, notwithstanding the apparent impossibility, a number of abortive treatments have been exploited in conservative journals and before representative societies, notably by the late Dr. John E. Woodbridge, of Cleveland, the originator of the well-known Woodbridge treatment, who claimed to have treated 1200 cases of typhoid without one death and to shorten the disease to 10 days or two weeks.

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Dr. Woodbridge, in a series of experiments, conducted at Fort Myer General Hospital, checked by Dr. James J. Curry, of Boston, and myself, lost four out of thirty-seven cases; two dying on the eighth, one on the fourteenth, and one on the eighteenth day after admission, and none recovering sooner than those in other wards.

Everywhere, so far, failure has been the result of attempts to abort typhoid, when impartially observed and reported and, in my opinion, the only logical hope of the future holds for us to reach that result is through the possibility of producing a typhoid antitoxin serum.

The indications we have to meet are to nourish the patient, support the heart, preserve the functions of the kidneys and other emunctories and minimize the probability of complications, for several weeks, while the patient is afflicted with an intestinal lesion prone to cause perforation or hemorrhage, due to bacilli liable by metastasis, to produce a pneumonia, phlebitis, etc., accompanied by a prolonged high rise of temperature, more or less delirium and stupor, probable diarrhea, marked anorexia and other usual symptoms. To meet these indications with the best results, we must use every means at hand with the best judgment, brains and common sense in our power.

Of the measures we have with which to meet these indications the most important is rest, and by this I mean as nearly absolute rest in bed as possible. The patient should not be allowed up for any reason and, even in a moderately severe case, should not be allowed to turn over in bed without assistance. By rest we save the patient's nutrition and strength, reduce the work of the heart and kidneys, to a certain extent keep down the temperature and more important than all else avoid, more than by any other means, the danger of hemorrhage, perforation and relapse.

Diet is almost if not quite as important as rest. I believe we should feed typhoid patients to their full capacity of digestion and assimilation; the diet should be the most nutritious, easily digested, with as little waste as posssible, but not necessarily liquid, though the inhibition of large quantities of liquids, especially water, should be insisted on. In my opinion, no danger exists in giving a typhoid patient, in any stage of the disease, *easily digested* solid or semi-solid food, and I do so without hesitation and have never regretted it, nor have I ever seen any harm done where ordinary good judgment was used. On the other hand, I consider it a serious error to insist on an absolutely liquid diet *in all cases,* and have seen many patients practically starved to death, either from lack of nutrition in the diet or inability to take the liquid diet that could be provided, and the physician positively afraid to give anything not in liquid form. Milk is always on the diet list of those who give nothing but liquid yet, when we consider the fact, that, while milk is liquid when it enters the mouth it is at least a semi-solid when it leaves the stomach and frequently remains so until it leaves the alimentary canal and appears as curds in the feces, it certainly is not strictly speaking a liquid food. I have never yet seen the waste of a properly cooked mutton chop, beefsteak, egg, stale bread, softened toast or the solid food that a sane physician would give any sick patient, appear in the stools and I cannot comprehend how they can be more liable to cause hemorrhage or perforation than the curds from milk or the coagulated parts of a liquid diet, as they are certainly in as liquid condition by the time they reach Peyer's patches, *if they have been fed within the limits of digestion.*

Do not understand me to condemn the use of milk or liquid foods with patients who do well on them, for I certainly do not, but on the other hand I do advocate not being afraid to use solid food when your patient will do better on it. Feed your patient to the limit of his digestion and assimilation on any easily digested food but do not go beyond his digestive capacity, and always bear in mind that any person sick, whether with typhoid fever, pneumonia or other disease accompanied by high temperature, cannot digest as well as in health.

Medicinal remedies I use as occasion requires, confining myself ordinarily to heart tonics and so-called intestinal antiseptics; using the latter not with any expectation of influencing the life, number or virulence of the typhoid bacilli, but rather with the hope that they may be of value in preventing putrefactive decomposition of the intestinal contents and its accompanying tympanites; but, to tell the truth, I think they are practically valueless.

Baths in various forms are an invaluable aid at all times, but their application should not be routine, but guided by the exigencies of the case and the welfare of the patient. The fever being the most constant symptom, is generally given the most constant treatment. In this I disagree in a measure with the majority, for I believe the rise in temperature, if there is a fair morning remission, of itself does no material harm; if steadily maintained at a high point for a long time it may. Our means of reducing the temperature should be restricted to some form of bathing. Coal tar preparations and other antifebrile drugs should be mentioned to be condemned, as they do far more harm through enfeebling the heart than good by reducing the temperature. The same is true of the external use of guiacol. Of baths we have the tub bath, the cold pack, sponging and so-called vapor bath; the tub is used exclusively in the Brandt method, but it requires so much disturbance of the patient that it materially increases the risk of hemorrhage or perforation, also the amount of shock is too much in some cases, even if given by thoroughly trained assistants and the danger of collapse is sufficient to bar it out in any case, where the assistants are not well trained and familiar with its use. In properly selected cases, especially robust, full-blooded patients in a nervous or delirious state with high temperature, these baths are of very great value. The cold pack will reduce the temperature nearly as much as the tub bath and with considerable less disturbance and shock to the patient and without danger of collapse. Sponging will usually reduce the temperature sufficiently, as well as allay the nervous condition, and is given with less disturbance than either the tub bath or cold pack.

The so-called vapor bath or vaporizing bath is not well known and hence not as often used as it deserves; it consists of covering the patient's trunk and each extremity with a layer or two of gauze on which water of a temperature of 105° to 110° F. is then sprinkled until the gauze is saturated and a couple of attendants vigorously fan the patient with large palm leaf fans, repeating the sprinkling as needed, until from one to three pints of water are vaporized, which should be done in 20 to 30 minutes. This will reduce the temperature from one to three degrees, apparently as permanently as a tub or pack, and being given with little disturbance or shock is especially applicable to very weak cases and children and those who cannot withstand the dread and shock of the various cold baths or sponging, and it is fully as efficacious.

Insomnia, restlessness, delirium and in fact all nervous symptoms are better controlled by the various forms of baths than in any other way and to my mind are a greater indication for using them than is the fever.

Diarrhea, unless exceeding five or six movements daily or evidently causing prostration, does not call for treatment. If so, a careful correction of the diet, washing out the lower bowel and if necessary a mild astringent will usually correct it.

For constipation, an occasional mild laxative or soap and water enema is all that is required.

Tympanitis requires a very careful revision of the diet list to see the food is properly digested. Any of the intestinal antiseptics as salol. chlorine water, carbolic acid and iodine or Novy's new acetozone may help. The last. from the very limited experience I have had with it, seems to me to be the best. Turpentine by mouth or rectum occasionally helps, but all told, the most good comes from correction of digestion.

The heart must be watched from the beginning and at the first indication of weakening, as indicated by increased frequency of the pulse, it must be stimulated. For this nothing is comparable with strychnin. When cardiac stimulants are begun they must continue regularly and be increased as needed. Subcutaneous infusion of saline solution is often of much benefit when the pulse is markedly dichrotic or of "water hammer" quality.

As to complications I have little to say. In a hemorrhage of the bowels, which occurs in 8 to 10 per cent. of all cases, the patient, in my opinion, is more dependent upon Providence than upon any physician. for the outcome will depend entirely upon the size of the eroded vessel. Absolute rest does more to prevent hemorrhage than all other means combined. and when it does occur possibly helps its arrest: as an aid in maintaining rest. quieting the nervousness and reducing the peristalsis of the bowel, opium in any form probably does some good but all other remedies or measures I consider useless. After the hemorrhage has ceased subcutaneous or intra-venous saline infusion is of the greatest benefit but decidely dangerous if given while the bleeding is still progressing. as the increased fluidity of the blood and force of the heart will diminish the probability of clotting at the open end of the artery. which is the only means by which the patient's life is saved.

Perforation of the bowel. if small and favorably situated for inflammatory agglutination to other coils of intestines or omentum, may possibly close and the patient live (I have seen two cases in which I think this occurred), otherwise the only treatment is surgical, with the big chance against the patient. In perforation as well as hemorrhage the greatest preventive is absolute quiet.

The treatment of other complications would be according to the indications and there is really no need to say more. You will see by the foregoing that I put my faith in what is called "expectant treatment," placing especial stress upon absolute rest, attention to digestion and diet, watching the patient carefully and intelligently and promptly meeting the indications as they arise and not over-treating.

All other methods, as the Brandt, the intestinal antiseptic and the eliminative treatments either alone or in various combinations have many good features which should be utilized, and in selected cases they are each undoubtedly the best, but I do not think the routine following of any of them is wise, as none is specific.

At Fort Myer I could, fortunately, observe the results in all methods used side by side. The mortality of the Brandt and intestinal antiseptic methods were about the same; more dying from hemorrhage, pneumonia and perforation under the Brandt method and more from cardiac failure through asthenia and relapses under the intestinal antiseptic method; the eliminative treatment gave a slightly higher mortality than the other two mentioned, through asthenia, hemorrhage and perforation and relapses were more frequent. This method probably would have given about equal results with the other two if we had not included the Woodbridge treatment under it. The Woodbridge treatment undoubtedly gave the poorest results of any and the death rate was the highest and hemorrhage and relapses much more frequent and the physical conditions of the patients the worst of any ward in the hospital; while the expectant method gave a slightly lower mortality record and fewer complications than any other form of treatment.

THE TREATMENT OF ACUTE, ANTERIOR GONORRHEA IN THE MALE, FROM A HYGIENIC, ASEPTIC AND ANTISEPTIC POINT OF VIEW.

By G. S. Peterkin, M. D.

SEATTLE, WASH.

(*Concluded.*)

Technic of Treatment.

The mechanical appliances necessary are an Ultzman's syringe, holding 25.50 cc., the silver pipe of which is of the usual caliber but straight and only four inches long. A urethral cap is also used which is a six-tailed bandage of gauze, the tails of which are four inches long and one and a half broad and radiate from the center like the spokes of a wheel. In the center of the gauze is a small piece of cotton, through which a couple of stitches are taken, that hold it and the gauze tails in place. To be applied over, but detached, is a square of dental rubber dam, five by five inches, an essential requisite in order to prevent the soiling of the under garments.

After the examination made at each visit, of the groins, external genitals, the discharge at the meatus, the character as it appears in the urine which is voided in ignition tubes (Thompson's three glass test), the patient's urethra is irrigated for cleanliness, as previously stated with a 1-6000 potassium permanganate solution. The patient then lies flat on the office table with genitals exposed, a sterile towel is placed beneath the penis over the scrotum; upon this the urethral cap, rubber dam and the Ultzman syringe, filled with argyrol solution, 40 to 90 gr. to the oz., according to the strength the urethra will stand, commencing with the weak solution. The meatus is then cleansed with a piece of cotton moistened with a solution, 1-4000 bichloride, a rubber band, according to the size of the organ is selected, usually the No. 8, as manufactured by Goodrich, being the size most adaptable. This is stretched over the middle and ring finger of the left hand, the head of the penis is grasped by the thumb and index finger of the right hand on each side of the frenum at the lower part, in order to steady the organ on the introduction of the syringe and to grasp the pipe and compress the urethra on its withdrawal, thus preventing the escape of the medicating fluid. The syringe is then taken in the left hand, the argyrol on the outside of the pipe being used to lubricate the meatus. The pipe of the syringe is now gently inserted as far as the constructor urethrae, the penis being held straight but not taut, after which the pipe is gradually withdrawn; the medicine meanwhile being constantly injected so as to cover the whole surface of the urethra. Then with the index finger and thumb, the right hand still grasping the urethra tightly, the urethral cap with the rubber on top is placed over the meatus, the elastic snapped on and the treatment is completed. The injection is retained for three hours, the time occupied in treatment usually being from ten to fifteen minutes, including examination and irrigation.

In using argyrol or other silver salts as above advised, it is to be remembered that they cannot be used indiscriminately or by rote. In some cases it may produce considerable reactionary inflammation and increase the discharge, so that it may have to be discontinued, or the strength of the solution modified. Usually, though, this will not be the case if the weak solution, 40 gr., is first used and its administration not commenced until after two or three days' irrigation, when it can be injected once daily or every other day, according to the sensibility of the urethra. The syringe at each injection must be thoroughly sterilized.

The following points in using this method of applying the medicine to the urethra are to be remembered. The normal capacity of almost every urethra varies with the individual. In the living body is from 4 to 22 cc. (Lavaux, Gruard, Loeb). The capacity likewise varies in an inflamed urethra, depending upon whether the stage is acute, subacute or chronic. During the acute stage, therefore, the urethra is to be very little if at all distended and the syringe is to be used to paint the surface of the urethra as it is withdrawn, after the manner of painting the vagina with a Furgeson speculum. On the subsidence of the acute stage, the amount of fluid must vary with the size of the urethra, the object being to inject the largest possible quantity, but not enough to cause pain by over distention, for then it cannot be retained.

On the patient's first visit a pamphlet is given him in this form and is entitled "General Directions" and contains the following instruction:

GENERAL DIRECTIONS.

If any of the discharge enters the eyes, it is apt, in 24 hours, to render the person permanently blind; therefore, never place your hands near the face while handling the inflamed parts; after handling, always wash your hands thoroughly and see that the towel is not used again. Do this to protect yourself and others.

Absolute rest in bed during active stage; after that, moderate exercise, so as to keep the body in good general condition, as walking over smooth roads, etc.; no form of violent gymnastics, especially cycling, horse-back riding and dancing. Should attend social affairs, theaters, etc., etc., but positively avoid sexual intercourse, even the loving attentions necessary to wooing, and all scenes, exhibitions, literature and conversation that will evoke lascivious thoughts, for by so doing, cure is not only delayed, but sometimes prevented.

During active stage take a hot sitzbath (that is, sit in bathtub and allow water to come nearly to belly button), from ten to twenty minutes every night (but before every bath or bathing of parts urinate); if sitzbath cannot be taken, soak organ in smaller vessel, in water as hot as can be borne, two or three times daily; in either case cleanse out the tub or vessel used with scalding hot water at least twice.

After every urination moisten new piece of cotton (first destroying old piece) with solution, or use a new G. U. napkin. Never apply dressing so close to the mouth of the organ that on taking it off there is an excessive flow of pent up discharge; dressing under any circumstances should be changed every two hours.

Always allow organ to hang down; never strip or endeavor by any manipulation to see if discharge is lessening.

Take daily baths, but before each bath urinate, dress the glands with cotton soaked in solution in bottle, and cover entire penis with well fitting condom; this will protect bather and those to come after.

Patient should go to bed early, sleep nine hours; matress should be hard, covering light and patient should sleep alone.

Towel should be tied around abdomen and knotted over back, so as to prevent sleeping on the back. These rules are to prevent congestion.

Should pass urine at least once during night; the best time is early in the morning. An alarm clock set two hours before the usual rising time will suffice as a reminder.

Always wear a suspensory bandage; after purchasing, have physician examine it to see that it fits well.

Avoid getting feet wet or encountering sudden change of temperature.

Any symptoms of ill health, especially of indigestion or constipation, report to physician.

DIETETIC: No alcoholic drinks; this includes beer and especially GIN. Smoking may be indulged in moderately, three cigars a day.

Drink a glass of pure water every hour or two; lemonade may be taken, but no effervescent drinks, such as soda, seltzer, etc.; may take one cup of tea or coffee each day.

In acute condition, that is, during presence of pain and profuse discharge, nothing but skimmed milk; after that avoid articles of food difficult of digestion, such as fried stuffs, pork, etc.; also red meats, or any food highly seasoned; fancy pastries, such as pies, rich puddings, etc., and anything which for any reason disagrees with the patient.

All meals should be taken regularly; lightest meal at night; no extra lunches, suppers, etc.

And it is to be borne in mind that by following out these instructions closely, the disease will be less painful and its duration shortened; that the disease is a serious one, often causing chronic invalidism and sterility in both sexes, sometimes death in men, quite frequently in women.

The purpose of this pamphlet is to cover, in a brief and definite manner, such instructions as are essential for the patient to know, in order to care for himself and protect others. Its use to the physician is that it consumes practically no time, omits no necessary instructions, can be easily altered to suit the individual case by crossing out those instructions deemed inadvisable. Later a second pamphlet is given the patient entitled "Gonorrhea or Clap" and contains excerpts from various papers on the prophylaxis and prevention of venereal diseases.

NORTHWEST MEDICINE

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THE WASHINGTON STATE ASSOCIATION MEETING.

Arrangements have been so far completed as to assure that the meeting in Seattle will be one of the largest and most successful on record. The program contains more numbers than that of any previous session, the subjects being varied and entertaining.

The Association will meet on Tuesday morning, July 12, at Christensen's Hall, in the Arcade Building. An innovation will this year be presented in the form of a president's reception, which Dr. Coe will hold at his residence, on the shores of Lake Washington, Wednesday noon, immediately following the morning session. At the same time he will invite the members of the Association, its guests and their wives to a luncheon on his lawn. The afternoon session will then be held at this place.

During this afternoon the wives of the local members will entertain the visiting ladies at a tea to be given at the Firloch Club, adjacent to Dr. Coe's residence, on the border of the lake.

Thursday evening will be devoted to a smoker at the Hotel Washington, followed by a supper. It is expected that all the visitors will remain for this social event, when they and the local members may come in personal contact.

We wish again to speak of the possibility of securing reduced railroad fares to Seattle. This depends on each visitor paying one full fare, at the same time taking a receipt for this from his local agent. If fifty of these are reported to the secretary of the meeting, the holders will be entitled to a return ticket for a one-third fare. This applies both to the Northern Pacific and Great Northern.

We trust the physicians of the state will be mindful of the fact that only once a year do we gather as a body, which is seldom enough to unite us in friendship and strength. It is to the advantage and profit of all of us to improve each of these occasions, and it is to be hoped the Seattle members may entertain a large attendance.

A MEDICAL DEPARTMENT FOR THE UNIVERSITY OF WASHINGTON.

The question of medical education in the Northwest is periodically presented. The present proposal to establish a two years' preliminary medical course at the University of Washington offers the opportunity for an expression of our views on this subject and the reasons for our earnest opposition to this innovation, which is shared by the profession at large in this northwest region.

It seems a fitting time to call attention to the fact that medical education has undergone a material change within the past ten years. The small medical school, poorly endowed, and hence poorly equipped, has no place today in medical education. Formerly, when didactic teaching was the largest part of the medical course, almost any doctor who could cram up authorities was considered competent to deliver a course of lectures, and whether competent or not he was pretty apt to do it, for the itching to be a medical professor or to be connected in some way with a medical school, was practically irresistible, and today, unfortunately for medical education, there remain a number of the ilk.

Tersely summed up, a medical education today consists of two years of the most intense application to laboratory work conducted entirely by educated medical men, who have a thorough perspective of the subject taught. For example, the anatomist must be a surgeon in order to properly teach his subject. The physiologic chemist must not only be a chemist, but a pathologist and a man capable of original research. The histologist is worthless, unless he understands the deviation from normal. The physiologist must be the rare combination of physiologic chemist and pathologist, if he would give the best results in his department. All must be thoroughly imbued with the importance of these two years in the life history of the medical student, for there, first of all, will be inculcated that thoroughly ethical medical spirit which must equip every man who enters the profession, if he would give the public the best that is in him. The prime purpose of medical education at the present time, in our best schools, is to instill in the mind of the student the fact that if he enters medicine with the idea that the pecuniary reward will be large, he must infallibly be disappointed, and the only satisfaction which cannot possibly be taken away from him will be the consciousness of work well done. As stated above, in the best medical schools, the teaching of the first two years is conducted by men specially trained and educated for the purpose. Their salaries are high, for they cannot practice medicine and properly conduct their courses. The laboratory equipment is special, and the attendant expense prohibitive except in richly endowed institutions, and even in these the schools are operated at a financial loss, no matter what the income may be.

May we not, in the face of this absolute necessity of medical education, ask that the smaller medical school should be abandoned, and all of the strength that comes from numbers and from a widely distributed support be concentrated upon the already well-equipped schools, where alone a thorough medical education can be obtained? There is room for just one first-class medical school on the Pacific Coast. That should not be outside of the city of San Francisco, where clinical material may be obtained in sufficient quantity to make bedside study of the last two years sufficient. It is a distinct wrong to the medical student to furnish him a course which is inferior to the best that can be had in the country, for the reason that he will be brought in competition with men so far his superior in attainment that, if conscientious, he must feel his inferiority, or if conscienceless, he is driven, or naturally gravitates into the ranks of the quacks and scoundrels generally, who prey upon the public under the guise of a medical diploma. It would be an exceedingly interesting study to classify the diplomas of men engaged in unethical and irregular medical pursuits and find out just what their equipment is likely to have been. The time has come when the medical profession must set itself solidly against the increasing number of medical schools, unless such school is endowed to an extent that will at once put it in possession of laboratories, faculties and clinical material second to none.

In view of these facts, we believe our position is unassailable that there is neither demand nor field for a medical school in the State of Washington, either as an entire institution or as a part of one that may lead to completion of a medical course elsewhere. We call upon the medical profession to present a united opposition against the establishment of such an institution.

NAMES IN MEDICINE.

One is struck as he reads the many works and articles that are written on various medical topics by the variety of names or titles that are applied to diseases, structures and methods. Many (and properly, no doubt) derive their names from Latin and Greek words and their derivatives, that combined give an idea of the nature of the disease in question and this, we think, is by far the most sensible system or method of nomenclature that is in use at present. Yet the tendency to coin new descriptive names seems to be almost a mania with certain writers who revel in the confusion (to one who is not a specialist in nomenclature) that they can make in words that have one or two letters different from others of the same root and combination to express an entirely different fact or procedure. "Choleolithotomy" reads well, sounds well, and is well, but it hardly appears any easier to say, sounds any more euphonious, or conveys any greater idea of learning or greatness than "removal of a gall stone" does. "Mastectomy" sounds well, and is well, but "removal of the breast" is easier and quicker comprehended by the ordinary practitioner of medicine and surgery, consequently of more service and so really a better expression.

Kindness is one of the attributes of a good physician, the expression "good" being taken in a general way as well as applied to professional attainments. It hardly impresses us as a matter of kindness for some one, perhaps thoroughly versed in the classics, perhaps of a remarkably retentive memory for descriptive technical terms, to constantly use terms that can only be above the heads of men of lesser educational attainments in the same line of thought and work, but whose ability to diagnose and treat a case, whose insight into human nature is far above that of the more learned man. One who talks to his professional brothers in classical language should be able, were he correctly constituted, to converse with all men as equals. The possibility of a complete preliminary education has not fallen to the lot of us all, and we have only praise and congratulations to offer to those who, in spite of their poverty in preliminary work, made great men of themselves, and feel with them their chagrin when those, more learned, talk above their heads. This is so much for the individual and to serve as a plea for simplicity in our profession.

If we look at those who have left themselves as standards of wisdom, we will find them models of simplicity. There are said to have been none more simple than Hunter, than Leidy, than Flint, than Rush, than Agnew, than Gross, or than hundreds of others of the same stamp who have been the forefathers of medicine, and by their efforts have led us up to our present condition. Such are the men whom we should imitate.

Yet another worse state of affairs is the habit of applying personal names to diseases, symptoms or methods of treatment and the structures of the body. How many of us in the profession can tell where and what the nerve of Wrisberg is? On the other hand, how few do not know of Hunter's canal. One applies to a very important relation in surgical anatomy, and the other to an anatomic structure that we are rarely called on to consider. Both could be better named. John Bright described nephritis and today it has become a family name to take the place of "kidney disease," and to us really should express nothing, for it is by the profession applied to so many forms of nephritis, but we still cling to it and on the face of it it is inaccurate. "Brodie's" abscess has clung to us for many years, and some teachers of surgery use as a question for final examination, "What is Brodie's abscess?" and to us all such a question can only appear as a rank injustice. "Potts'" fracture and "Potts'" disease, common as the terms are, convey no information to some people who belong to the profession, though we admit that they should. So with "Colles'" fracture, and some one not long ago asked, "At what distance above the articulation does a fracture cease to be a "Colles'?" Not long ago some one spoke of adjusting to a case of fracture of the femur, a Buck's extension. "Buck's" extension had to be explained, though we knew how to put on the common extension for such cases.

But yet comes the worst collection of all, in nervous diseases. Dr. Mitchell comparatively recently described "red neuralgia" for which he was pleased to coin the word "erythromelalgia" (rather large and cumbersome), but some friend and admirer has not been content to allow it to so stand, but calls it "Mitchell's" disease. It was no doubt meant as a compliment and honor to this most illustrious man who first singled out the symptom of the disease as a separate entity, though by so doing much has been added to the confusion that already exists in a very long and extremely cumbersome and unpronounceable name, though it be perfectly correct.

Graves' disease, Basedow's disease and Exophthalmic Goitre all apply to the same condition, the latter indicating more than both the others, and carries in itself some information to the mind of the common practitioner. The absurdity of the affair in hand can better be illustrated by one instance more. Progressive bulbar paralysis is called Duchenne's disease, Trousseau's disease, Leydens' disease, Wernicke's disease, etc. Romberg's sign, the name of a condition, is a term in general use. However, we looked in a number of convenient places for the name and failed to see it, and also read one or two accounts of the disease and failed also to find the famous name of Romberg. Though we are aware that there are many good descriptions of locomotor ataxia in which it can be found, we venture the statement that not one practitioner out of twenty-five would in any way connect the disease and the sign. Measles and Koplik's sign are associated, but how few men associate the two names.

It appears perfectly absurd to us to constantly and continually indulge in this proper name farce, though by making the statement we do not wish to detract from any honor that should be conferred upon the original description of the disease, sign, operation, or whatever it may be applied to. It is far more sensible, simple, elegant and expressive to use words that convey some meaning to our associates than to plume our writings and sayings with many inexpressive names of men. Richness and elegance are in all walks of life more noteworthy when simple, and so it strikes us that the most elegant language is that where simple, well chosen words are used that are capable of easily conveying their meaning. NORTHWEST MEDICINE desires to add its mite to the encouragement of those of our profession who would be as simple as possible in all their doings.

MEDICAL NOTES.

The Thirty-seventh Annual Meeting of the Canadian Medical Association.—We wish again to remind the profession of the Northwest of this meeting in Vancouver, from the 23d to the 26th of August. This is to our Canadian medical friends what the American Medical Association is to us, the national association of the profession. It is only at long intervals that either organization holds a session on the Pacific Coast, and it is fitting that the local profession secures all possible benefit from such a gathering. While a marked distinction is conferred on the city of Vancouver by entertaining this distinguished body of practitioners, this is also reflected on the whole Northwest section.

The meeting will open at 10 a. m. on Tuesday, the 23d of August. Mr. Mayo Robson will deliver an address on surgery; Dr. C. E. Dudley will deliver an address on gynecology. There will be numerous papers read by men prominent in the profession, both from Eastern Canada, United States and Great Britain.

The Entertainment Committee have arrangements made so that the ladies accompanying the fraternity will be well provided with entertainments during the time the meetings are being held.

There will be excursions to various points of interest in and around Vancouver, yachting, tramway and train excursions.

On Thursday afternoon there will be an excursion to New Westminster, visiting the Asylum and various other points of interest there. Thence they will take the boat down the famous Frazer River to Steveston, where our visitors will have an opportunity of seeing British Columbia salmon canned, and then return to Vancouver by train.

Evenings that are not occupied by business of the Association will have some form of entertainment provided. On Friday it is proposed to take the steamer to Victoria and in the afternoon attend a garden party at Government House, and in the evening a reception at the Parliament Buildings.

On Saturday, those who desire, will have an opportunity of visiting Williams Head Quarantine Station and Esquimalt, the Gibraltar of the Pacific Coast.

It would be advisable for all those coming to forward their names to the Local Secretary, W. D. Brydone-Jack, at least two or three weeks before the meeting, so that suitable accommodation may be provided for them without any inconvenience at the time, as a large number are expected to attend. Hotel rates range from $2.00 to $5.00 and rooms from $1.00 to $2.00 per diem.

We feel that the American physicians, tributary to British Columbia, should take advantage of this opportunity to become acquainted with the leading practitioners of our sister nation as well as to reap the benefit from the gathering of so many distinguished men of scientific and medical note. This will be a convenient season for many to take a vacation from usual work and it is hoped that we will be well represented at this meeting.

The American Medical Association in Portland.—We extend our congratulations to the Portland profession for their success in securing the meeting for their city in 1905. The physicians of Washington join those of Oregon in feelings of pride and satisfaction at the prospect of beholding this representative body in session in its own corner of our land. We realize that the local profession has a very large contract on hand to prepare for and entertain the Association but, knowing the energy and ability of the men of Portland, we are confident that the meeting will be conducted to a successful issue and prove to be the most satisfactory ever held in the West.

The Quarterly Meeting of the Chehalis County Medical Society.—This is a live county society that holds regular meetings and aims to get out the members on such occasions. The inducements for the present quarterly session are presented in the following attractive manner:

It is to occur, and you are requested to be there, the Second Quarterly regular meeting of our County Medical Society at the office of Dr. M. Rob Stapp, of Aberdeen, Tuesday Evening, July 5, 1904, just one week before our State Society meets. Lay down your scalpel and

Rx book for an evening for a profitable and sociable time. It will be meat to your soul and marrow to your bones.

PROGRAM.

1. Progressive Muscular Atrophy—by Dr. H. C. Watkins, of Hoquiam.
   Discussion by Dr. M. L. Pearson, of Aberdeen.
   " " Dr. Wells, of Hoquiam.
2. Pertussis—by Dr. M. L. Pearson, of Aberdeen.
   Discussion by Dr. M. Rob. Stpp, of Aberdeen.
   " " Dr. H. Blair, of Elma.
3. Diagnosis and Treatment of Fractures About the Hip Joint—by Dr. H. Campbell, of Hoquiam.
   Discussion by Dr. M. Rob Stapp, of Aberdeen.
   " " Dr. D. A. Schumacher, of Aberdeen.
4. Eclampsia—by Dr. J. S. Walston, of Montesano.
   Discussion by Dr. T. R. Watkins, of Aberdeen.
   " " Dr. French, of Elma.

The State Medical Examining Board.—Drs. F. H. Coe, of Seattle, and P. B. Swearinger, of Tacoma, have been reappointed to serve another term on the board. The summer examination was held at Spokane, July 5, 6 and 7. A large class was in attendance, as has been the rule for several years.

American Association of Life Insurance Examining Surgeons.—At the annual meeting of this Association, held at Atlantic City, June 6, an honor was conferred on the State of Washington, when Dr. H. W. Dewey, of Tacoma, was elected Third Vice-President.

TO OUR READERS AND CONTRIBUTORS.

All material for publication must be received by the twentieth day of the month preceding a given issue. Articles will be illustrated by half-tones or etchings when accompanied by photographs or drawings for the same. Reprints of contributed articles can be obtained at the cost of publication, from the Metropolitan Press, publishers of the Journal. A limited number of additional copies of the Journal will be supplied to contributors, if a request is made for them.

TO ADVERTISERS.

We wish to call attention to the fact that Northwest Medicine has no department for reading notices, publishers' notes, etc., and that the literary and advertising pages are entirely distinct.

REPORTS OF SOCIETY MEETINGS.

KING COUNTY MEDICAL SOCIETY.

President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

The first regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce, on the evening of June 6, President Heg being in the chair. Thirty-three members and visitors were present.

Dr. H. E. Allen was elected to membership. The name of Dr. Horsfall was proposed and referred to Committee on Admission.

A letter was read from the Chairman of the Committee on Medical Legislation of the A. M. A., stating that Dr. J. H. Lyons had been appointed as a member of the National Auxiliary Congressional and Legislative Committee, to serve in and for King County.

It was voted that the meetings of the Society be suspended for the months of July and August, subject to the call of the Secretary, for a special meeting early in July.

CLINICAL NOTES.

Dr. Winslow presented radiographs of the knees and adjacent bones of a 14-year-old boy who had, within a few weeks developed swellings below the patella, on the tibiae, that are painful to touch and cause stiffness of the knees. About one and a half years ago he had rheumatic fever. No tubercular nor syphilitic history. The radiographs show enlargement of the tibiac at the affected areas, with some apparently loose splinters of bone or periosteum. The doctor thought it probably a case of periostitis. There had been no traumatism to act as exciting cause.

PAPER AND DISCUSSION.

Pathology and Diagnosis of Benign Inflammations of Bones and Joints.—Dr. Read presented this paper, giving a careful review of the histology of bone and anatomy of joints, preliminary to the discussion of the pathology of bone disease. He dwelt especially on bacterial invasion as an etiologic factor and described the general pathologic conditions found in inflammations of the bones.

Dr. Sweeney opened the discussion with interesting comments on the facts presented.

Dr. Dawson mentioned a child three years of age who had attack of typhoid fever followed by swellings on a rib and the tibia. He cut down on both, found pus and curetted them. They recovered and now there is recurrence of swelling and hardness over the tibia. She is in apparently good condition and without fever. Possibly the typhoid bacillus is responsible for the pus in such a case. The question arises whether let it alone or operate on it.

Dr. Willis described a case of typhoid which developed an abscess over the tibia which healed readily after incision and packing. In a few days one appeared on the other tibia which, after like treatment, failed to heal but did so after a second operation.

Dr. Hawley said the essayist had pointed out an important fact in the relation of the thyroid to disease of bone and with any disease of the typhoid we should think of the possibility of bone disease. Very little is found in the text books on the subject.

The second regular semi-monthly meeting of the King County Medican Society was held at the Seattle Chamber of Commerce on the evening of June 20. In the absence of the President and Vice-President, Dr. Smith occupied the chair. Thirty-seven members and visitors were present.

Dr. Coe addressed the meeting on the subject of the proposed preliminary course in medicine which is to be introduced at the University of Washington. He reviewed the argument against the establishment of another medical school and mentioned his personal interviews with President Kane and other members of the faculty on this subject. It was voted to appoint a committee of six to wait upon President Kane, to present to him the views of the profession and ascertain the details of the proposed departure. The following were appointed: Drs. Reed, Dawson, Smith, Parry, Pontius and Harris. A second committee, composed of Drs. Coe, Willis and Schoenle, was appointed to draw resolutions for presentation to the University Board of Regents, expressing arguments in opposition to the contemplated medical course.

PATHOLOGIC SPECIMEN.

Dr. Willis exhibited a cystic fibroid of large size and explained the peculiarities of the case. The patient had passed the menapause and recently begun to flow somewhat. The tumor was uniform in size, about equal to a seven months pregnancy.

PAPER AND DISCUSSION.

The Diagnosis and Prophylaxis of Smallpox.—Dr. Moore read this paper, giving a description of the characteristic symptoms of the disease, together with the appearance of atypical cases. He quoted statistics to prove the efficiency of vaccination in diminishing small pox. He gave a description of cases of interest that had come under bis observation as county health officer, dwelling on the carelessness and indifference of the laity and some of the profession as to the necessity of vaccination.

Dr. Schoenle discussed the disease from the standpoint of a dermatologist, mentioning several skin diseases that are often mistaken for this. He referred to a case in this city some years ago where a prisoner in the city jail produced an eruption simulating small pox by the application of croton oil. He was sent to the pest house and at once escaped.

Dr. Dawson related his experience with the disease in connection with the Washington Volunteers who went to the Philippines. A surprisingly large number had never been vaccinated. Before they reached their journey's end they were repeatedly vaccinated, some as many as seven times before proving successful. Only two of the regiment failed entirely. In service only a single case of varioloid appeared though the troops were in constant contact with the disease, while some other regiments had numerous cases and a high mortality. He commented on the prevalence of the disease among the natives, a very large proportion of whom have had it. They made no attempt to avoid it and vaccination had not been practiced.

Dr. Chidester, of the U. S. Army, gave a similar experience in the Orient with the regular troops, few of them suffering from the disease on account of repeated revaccinations. He described the prevalence of small pox in that portion of Luzon where he was stationed. It was decided to vaccinate the population which was at first done by compulsion till 300,000 were thus treated. When the good effects were comprehended the subjects appeared willingly. During his residence in that district the disease was almost eliminated by these measures.

Dr. Allen presented like testimony concerning his observations of the disease and its prevention during his service in the islands.

Dr. Smith said that his experience some years ago impressed him with the desirability of considering all cases of chicken pox in adults as small pox till proven to the contrary. He related a hospital experience where two patients in succession were considered chicken pox until a series of small pox cases developed, of undoubted diagnosis.

Dr. Miles criticized the essayist's statement that the period of incubation extended from 8 to 20 days, claiming that it was almost invariably 14 days, as supported by the authorities.

PIERCE COUNTY MEDICAL SOCIETY.

President, C. Quevli, M. D.; Secretary, A. de Y. Green, M. D.

The regular monthly meeting of the Pierce County Medical Society was held in the parlor of the Tacoma Hotel on June 21, 1904, at 8:45.

In the absence of the president and vice-president, Dr. Bean called the meeting to order.

Drs. C. A. Stewart, W. B. Van Vetchen and J. W. Moore were elected to membership.

The program of the evening was a paper read by Dr. Stimpson on Minor Surgery and its Treatment. Dr. Stimpson enthused the members with such interest that a lengthy discussion followed by all present.

The meeting adjourned at 10:30, subject to the call of the president.

WHATCOM COUNTY MEDICAL SOCIETY.

President, D. E. Biggs, M. D.; Secretary, W. N. Hunt, M. D.

The regular meeting of the Whatcom County Medical Society was held June 13 in the Odd Fellows' Hall, Bellingham. President Biggs occupied the chair.

Dr. Markley reported that the Committee on Ethics had caused the county attorney to notify persons practicing medicine illegally to comply with the law or cease practicing in the county.

On motion of Dr. Smith the thanks of the Society were extended to the Committee on Ethics for their efforts in trying to rid the county of illegal practitioners.

PAPER AND DISCUSSION.

The paper of the evening was contributed by Dr. A. T. Kaupp, on the subject of Pleurisy. The different varieties of the disease were described in detail and the entire subject discussed in a thorough manner.

Drs. Smith, Markley, Johnson, Biggs and Hunt took part in the discussion which followed.

RECENT PROGRESS IN MEDICINE AND SURGERY.

GENITO-URINARY DISEASES.

Edited by
G. S. PETERKIN, M. D.; G. W. HAWLEY, M. D.

An Inquiry into the Value of the Irrigation Method as a Means of Aborting and Treating Acute Specific Urethritis. By Dr. Orville Horwitz, B. S., M. D., Therpeutic Gazette, March, 1903.

A very careful and impartial consideration of the value of the irrigation treatment in acute specific urethritis is presented by Dr. Horwitz. This method, which has been popular for the past few years, is theoretically and clinically analyzed and its advantages and disadvantages pointed out. He notes the increasing abandonment of the method among specialists and quotes many conservative surgeons who condemn it as less efficient and more harmful than injections with the non-irritating, gonococcicidal silver preparations. He concludes that:

The irrigation treatment does not abort gonorrhea.

The terminal stage is hastened but prolonged.

Chronic urethritis and extension to deeper parts are usual sequences.

It should not be employed in the acute stage.

In many cases it has to be abandoned and other methods used to effect a cure.

Irrigation of the posterior urethra in gonorrhea is conducive to complications. HAWLEY.

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400 Operations for Vesical Stone—Blasensteinoperationen. By Prof. A. von Frisch. Wiener klin. Wochenschrift, XV, Nos. 13-15.

von Frisch reviews, analyzes, and draws conclusions from his own rich experience in vesical lithiasis upon a very large and varied group of cases extending over a number of years. The different forms of stone, symptoms, complications, and sequelae are discussed and illustrated by cases and numerous cuts. He considers in particular detail the operative treatment—cystotomy and lithotripsy. The indications, dangers, after-treatment, and results of each are elaborately presented. He maintains that the crushing operation is unquestionably the operation of choice but points out that all cases are not amenable to this procedure and emphasizes the importance of differentiating between cases fit for the lithotrite and those in which crushing would be difficult or impossible. Much reliance is placed upon the cystoscope in determining the number, size, shape, and nature of stones—also diverticuli and trabeculation of the bladder. His conclusions are based on operative results. In 306 of his cases lithotripsy was done, with a mortality of 2.6 per cent. and recurrence in 8.2 per cent. In 94 cases operation was by suprapubic cystotomy. Of these 12.7 per cent. died and recurrence took place in 12.8 per cent. The technic of the modern crushing operation is carefully described. von Frisch has operated both under local and general anesthesia and, as a rule, without hemorrhage. The following day the patient is up and about. HAWLEY.

Symposium on the Surgical Treatment of Bright's Disease. Chicago Surgical Society and Chicago Medical Society. Journal of A. M. A., Jan. 23, 1904.

The conclusion drawn by this able and conservative body of surgeons and physicians place more than an uncertainty as to the value of surgical intervention in nephritis. While it was admitted that benefit sometimes does result, it was maintained that the operation of decapsulation was not well established and should even receive the stamp of disapproval. This position was upheld by the statistics advanced by Dr. A. R. Elliott. The total number of cases available from the literature were 76. The mortality was 47.3 per cent., and 65.8 per cent. failed to be benefited. The importance of differentiating between suitable and unsuitable cases was brought out as well as between those for which nephrectomy, or nephropexy would suffice, and those fit for Edebohl's operation. Dr. G. F. Suker illustrated the importance of ocular phenomena as indicating with precision contraindications to operation. According to his observations, a retinitis or a neuroretinitis absolutely contradicts decapsulation, the mortality being—when such lesions are present—practically 100 per cent. HAWLEY.

The Newer Methods of Investigation and Results of Operation in Kidney Affections. By Prof. H. Kuemmell, Archiv f. klin. Chir. LXXII, No. 1. Quoted Journal of A. M. A., March 5, 1904.

Kuemmell, who has investigated and declared in favor of the new methods of functional kidney diagnosis, reviews his former experience in renal surgery and that since his adoption of more careful tests. His large experience permits him to speak with authority and offers practical proof of the value of these methods. In 168 operations upon the kidney his mortality was 28 per cent. This has dropped to 8 per cent. in 98 cases since using the functional tests. He further adds that this should in reality be 4.8 per cent., for the reason that he operated in one case against the evidence of the tests.

HAWLEY.

Gonorrheal Inflammation of Joints. By A. E. Halstead, M. D., Chicago, Ill., International Journal of Surgery, March, 1904.

The author briefly reviews the history of the disease, stating that gonorrheal rheumatism was recognized clinically before it was known that the gonococcus was the primary cause of the disease. In searching for the gonococci in joint inflammation they should be looked for in the detached endothelial cells and the leucocytes rather than in the fluid itself.

Clinically he groups the gonorrheal inflammation of the joint as follows

1. Acute serous synovitis.
2. Acute sero-purulent synovitis (mixed infection).
3. Purulent synovitis (usually mixed staphylococcus and gonorrheal infection).

4. Sero-fibrinous or the sero-membranous, of Ollier, where the fluid is present in small amount, or has the consistency of coagulated serum or is gelatinous.

5. The peri-articular, ankylosing inflammation, with practically no fluid in the joint cavity. In this group we have a low grade of inflammation, closely simulating arthritis deformans, and usually associated with considerable pain, marked muscular atrophy, and pronounced anemia.

He then goes on to describe the clinical, symtomatic and pathologic character of these subdivisions of gonorrheal inflammation, following it by some remarks upon differential diagnosis between this disease and other articular infections, as for instance, the monarticular character of the disease. It is often ushered in with a chill, symptom not common to articular rheumatism. Sweating is not as pronounced as in rheumatism. The pain in gonorrheal synovitis is more acute and does not yield so readily to the salicylates as does rheumatism. Muscular atrophy, ankylosis and deformity are more common in the protracted cases; in aspiration of the joint when the effusion is large, and filling endocarditis is a less frequent complication. The most important fact in the diagnosis, however, is the presence of the gonococcus in the secretion of the urethra, vagina or uterus.

As to treatment, he states it differs according to the type of the disease present; believes in large doses of salicylates of soda in acute cases; in aspiration of the joint when the effusion is large, and filling the cavity with a 1 per cent. solution of protargol, after which he secures immobility of joint by application of a plaster cast for one week, which is later followed by massage and passive motion when the condition of the joint so indicates. Diagnostic puncture is strongly advised, the advantage of which is the early recognition of mixed infection and the advisability when to resort to arthrotomy and drainage, and that this proceedure is immediately indicated when the fluid is sero-purulent or purulent. For the more chronic forms of this disease his treatment consists of arthrotomy, lavage of joints, massage, passive motion, superheated air, etc., as indicated. PETERKIN.

BOOK REVIEWS.

Edited by
KENELM WINSLOW. M. D.

Progressive Medicine. June Number, 1904. Edited by Hobart Amory Hare; Lea Bros. & Co., Phila. and N. Y. $6.00 per annum.

Of this quarterly we have often spoken favorably in NORTHWEST MEDICINE; it would be impossible to do otherwise. The present number contains contains contributions to progress in Surgery of the Abdomen by Wm. B. Coley; to Gynecology by John G. Clark; to Diseases of the Blood; Diathetic and Metabolic Diseases; Diseases of the Spleen, Typhoid Gland, and Lymphatic System by Alfred Stengel, and Opthalmology by Edward Jackson.

Coley devotes considerable attention to recent progress in the study of hernia, on which subject he is himself a high authority. Mayo's operation for umbilical hernia is recounted, although the credit for transverse coaptation of the structures of the abdominal wall in the cure of this hernia is given primarily to J. Collins Warren of Boston. The treatment of acute peritonitis followed by the most advanced surgeons is related, including enterotomy in distention of the bowels and introduction of saturated solution of epsom salts directly into the gut; also the use of the half-sitting posture. The pro's and con's of drainage are discussed. A great deal of space is devoted to surgery of the stomach and intestinal suture. McGraw's elastic ligature is described in detail and current experience of the same is given. The appendix receives its share of notice. Ochsner's treatment is discussed by leading lights, favorably and otherwise. The surgery of the liver, biliary passages and of the pancreas in its most recent developments is accorded 34 pages, which reflect the opinions and work of the most able workers in this field. Clark gives us all the latest knowledge concerning cancer and fibroma of the uterus, pelvic infection, and gonorrhea in women. There is a most interesting account of the function of the corpus luteum as interpreted by the researches of Ludwig Fraenkel. His investigations apparently indicate that the corpus luteum is a gland; that its internal secretion determines the menstrual activity of the uterus and the implantation and development of the fecundated ovum. This experimenter believes that the corpus luteum is essential to the normal nourishment of the uterus—after the destruction of the corpora lutea the uterus of non-pregnant animals undergoes atrophy. The dried corpora lutea of the cow have much more efficiency in relieving distressing symptoms of the artificial climacterium than has ovarian extract because these are the only active parts of ovarian tissue. Clark's section closes with a consideration of diseases of the female urinary system.

Stengel occupies 42 pages with the pathology of the blood and gives a most exhaustive review of the most recent literature concerning rheumatoid arthritis, gout, and diabetes. Infantile scurvy, tuberculosis of the lymphatic system and that rare disease in which there is pigmentation of the cartilages—ochronosis—are considered in the light of our latest knowledge. The remaining 29 of the 325 pages are given to opthalmology. For a detailed account of progress in medicine and surgery, including all their specialties appearing in a systematic form, there is no publication equal to Progressive medicine, in English. The files of this publication record in detail the history and progress of modern medicine. All of value is selected from the work of scientific men all over the world by those most competent to sift the wheat from the chaff. WINSLOW.

Concerning the Effects of Saline Waters (Kissingen and Homburg) on Metabolism. By Dr. Carl von Noorden. 5½x8¼ inches. 89 pp. Cloth, 75 cents. E. B. Treat & Co., New York.

This is Part V. of the Clinical Treatise on the Pathology and Therapy of Disorders of Metabolism and Nutrition, most of which we have reviewed in these columns before. Dr. Carl Dapper collaborates with von Noorden in the present volume. The subject has a wider interest than would at first sight appear from the title, for the saline waters represent in fact the action of sodium chloride solutions and embrace a large group of mineral waters including Apollinaris. To summarize briefly the results of the author's experiments: we find that the use of saline waters (sodium chloride solutions) leads to marked and permanent increase in the production of HCl in many gastric disorders where there is deficiency of this acid—notably in chronic gastritis.

That, conversely, in many gastric disorders with hyperacidity the moderate use of saline waters causes a diminution of HCl formation with corresponding improvement in the subjective symptoms—notably in nervous dyspepsia.

That the metabolism of the proteids is not increased by saline mineral waters so that their use is not attended by any wasting of the albumin-content of the body, but on the other hand, the metabolism of nuclein or purin bodies, from which uric acid is formed, is increased with accompanying augmentation of uric acid elimination.

The use of saline mineral waters is then of advantage in the treatment of gout and other conditions with uric acid retention. Finally von Noorden explodes the necessity of certain rules which have been heretofore considered imperative at the baths, namly, that the administration of saline mineral waters requires any particular dietary accompaniment. He shows that there is no reason why large quantities of fat should not be given to suitable cases who are taking the waters and that there is no sufficient objection to the use of raw fruits, vinegar and salads in appropriate cases. Heretofore custom has forbidden such articles of diet to the disadvantage of the patient, but von Noorden proves that arbitrary rules of diet are ridiculous and that the special condition of the patient should alone guide us in these matters. The general practitioner would do well to procure these little treatises, especially those on Nephritis, Colitis and Acid Autointoxications. All of them disprove much of the text book teachings but offer in their place new and illuminating knowledge based on a happy combination of sound clinical and ingenious laboratory work. WINSLOW.

REPORT OF CONTAGIOUS DISEASES.

To the Washington State Board of Health for May, 1904.

Counties.	Smallpox		Scarlet Fever		Diphtheria		Typhoid Fever	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Adams	4	0	8	0	0	0	0	0
Chehalis	0	0	1	0	0	0	0	1
Chelan	0	0	0	0	2	0	0	0
Clallam	0	0	0	0	1	1	0	0
Columbia	0	0	2	0	0	0	0	0
Cowlitz	1	0	0	0	0	0	1	0
Jefferson	0	0	0	0	1	1	0	0
King	4	0	29	3	12	1	3	0
Kitsap	0	0	17	2	4	2	1	0
Lincoln	4	0	4	0	0	0	0	0
Mason	0	0	0	0	1	0	0	0
Pacific	0	0	0	0	10	1	1	0
Pierce	1	0	0	0	2	0	2	0
San Juan	0	0	0	0	0	0	1	1
Skagit	0	0	0	0	0	2	0	0
Snohomish	2	0	0	0	0	0	0	0
Spokane	1	0	4	0	7	1	0	0
Thurston	0	0	0	0	2	0	0	0
Walla Walla	0	0	0	0	1	0	2	0
Whatcom	0	0	23	2	7	0	0	0
Whitman	3	0	1	0	0	4	0	0
Yakima	2	0	1	0	9	4	2	0
Seattle (city)	10	0	21	1	22	1	8	4
Spokane (city)	6	0	9	0	11	0	5	3
Tacoma (city)	1	0	3	0	2	0	5	1
Total	39	0	123	8	96	16	31	10
Total May, 1903	70	4	98	3	18	4	0	0
Total 1904	221	1	679	31	500	72	213	58
Total same period 1903	541	4	415	8	98	7	0	0

ELMER E. HEG, Secretary.

MEDICAL SOCIETIES.

Name. Meetings Held.

Washington State Medical Association.........July 12, 13, 14—Seattle
President, F. H. Coe, M. D.; Secretary, A. H. Coe, M. D.

Chehalis County Society ....Second Tuesday—Aberdeen
President, D. A. Schumacher, M. D.; Secretary, J. W. Scamell, M. D.

Chelan County Medical Society...............................
President, W. M. McCoy, M. D.; Secretary, H. A. Saunders, M. D.

King County Society ....First and Third Monday—Seattle
President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

Pacific County Society ....
.............Third Monday of Jan., April, July, Oct.—South Bend
President, G. W. Overmeyer, M. D.; Secretary, Mary W. Gunwell, M. D.

Pierce County Society.............First and Third Tuesday—Tacoma
President, C. Quevli, M. D., Secretary, A. de Y. Green, M. D.

Skagit County Society ....
President, A. C. Lewis, M. D.; Secretary, R. J. Cassel, M. D.

Snohomish County Society...................First Tuesday—Everett
President, C. A. Mead, M. D.; Secretary, James Chisholm, M. D.

Spokane County Society....................First Thursday—Spokane
President, G. S. Armstrong, M. D.; Secretary, Geo. A. Gray, M. D.

Walla Walla County Society.........Second Wednesday—Walla Walla
President, N. G. Blalock, M. D.; Secretary, Y. C. Blalock, M. D.

Whatcom County Society..................Second Monday—Whatcom
President, D. E. Biggs, M. D.; Secretary, W. N. Hunt, M. D.

Whitman County Socity.........Third Monday of Jan., Apr., July, Oct.
President, W. N. Divine, M. D.; Secretary, R. J. Skaife.

Yakima County Society..............First Tuesday—North Yakima
President, David Rosser, M. D.; Secretary, Carver, M. D.

Oregon State Medical Association......................1904—Portland
President, W. T. Williamson, M. D.; Secretary, L. H. Hamilton, M. D.

City and County Medical Society of Portland...First Wed.—Portland
President, R. L. Gillespie, M. D.; Secretary, A. D. Mackenzie, M. D.

Multnomah County Medical Society..........First Tuesday—Portland
President, A. Tilzer, M. D.; Secretary, L. Victoria Hampton, M. D.

Montana State Medical Association 1905
President. B. C. Brooke, M. D.; Secretary, Grace W. Cahoon, M. D.

Silver Bow Medical Society....Second and Fourth Wednesdays—Butte
President, T. J. Murray, M. D.; Secretary, Grace W. Cahoon, M. D.

Idaho State Medical Association............October 6 and 7—Lewiston
President, J. L. Conant, Jr.; Secretary, E. E. Maxey, M. D.

North Idaho District Medical Society..............June 9—Lewiston
President, C. L. Gritman, M. D.; Secretary, C. D. Parsons, M. D.

South Idaho District Medical Society.............July 2—Idaho Falls
President, H. A. Castle, M. D.; Secretary, E. W. Kleinman, M. D.

Canadian Medical Association............Aug. 23, 24, 25—Vancouver

British Columbia Medical Association...............1904—Vancouver
President, A. P. Procter, M. D.; Secretary, W. D. Brydone-Jack, M. D.

Vancouver Medical Society ....Vancouver
President, W. D. Brydone-Jack, M. D.; Secretary, J. S. Conklin, M. D.

Corrections and additions to this list are requested from societies reached by this journal.

FRANTZ H. COE, A. B., M. D.

1856—1904.

President Washington State Medical Association 1903-1904.

NORTHWEST MEDICINE

August, 1904.

PRESIDENT'S ADDRESS.*

By Frantz H. Coe, M. D.,

SEATTLE, WASH.

In opening this fifteenth annual meeting of the Washington State Medical Association the mind naturally reverts to our first session, held at Tacoma, in 1889. Some are with us today who were then present. We recall with pleasure many of the speeches then made, forecasting so perfectly the growth in wealth and in importance of the then infant state, and the desire so often expressed that a medical profession in every respect worthy of a great state, might then and there be organized into a unit, effective for good to its people, as well as for the advancement of its members in medical knowledge. No sentiment of selfish professional interest was then expressed, nor has any such sentiment ever ruled our deliberations. Year after year has seen a steady improvement in the quality of the papers presented; showing in many cases entirely original work, or when not, always showing that the original discoveries of able ivestigators, with their resultant suggestions, have been grasped by an intelligent and progressive class of medical students. How almost miraculous have those discoveries been.

At the meeting in 1889 many of us had recently come from the best schools, but who then fully grasped the wonderful possibilities of bacteriology with its ultimate developments in aseptic surgery, and the treatment of diseases heretofore intractable or incurable? The receptiveness of the profession in the past leads me to predict that the splendid investigations in the hemolysins, cytolysins and agglutinins will find earliest recognition from the members of this Association.

It is a matter of profound regret that illness has prevented the attendance of one of the ablest medical men in this country, who had promised to teach us the application of these recently discovered physiologic agents. Is it generally known that the toxins of typhoid fever, diphtheria, anthrax, etc., are now being produced by the quantity—we might almost say by the pound—in Vaughan's laboratory, and a new direction is thus given to immunity investigation? We must keep ourselves in a receptive attitude, for great discoveries lie just ahead of us. But what are, and what can we be doing, to advance the standard of professional work? This naturally leads us to consider, first, the work of the State Board of Medical Examiners, and then the status of medical education, locally and at large.

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*Read before the Washington State Medical Association, Seattle, Wash., July 12, 13 and 14, 1904.

As required by the statute, the State Examining Board is composed of nine members appointed by the Governor of the state, each for a term of three years, or until his successor is appointed, and who shall be learned and skilled in the practice of medicine and surgery. The law gives much power to the Board in determining the qualifications of proposed practitioners, and was intended primarily and solely to act as a protection to the people of the state, securing for them the services of thoroughly competent physicians. Such a law must of necessity be defective in securing absolutely perfect results, but so long as the purpose mentioned controls the action of the board, only good can follow, no matter if, as is inevitable, some hardship accrues to individual members of the profession. For example, some requests come to us for reciprocal relations with other states. So long as the full tide of immigration is setting this way, and so long as from one to two hundred medical men, trained in the best schools of the country and not in the least fearful of any reasonable examination are to be obtained yearly, the Board fails to see where the state would be the gainer by reciprocity. The dissatisfied, the unsuccessful, and the antedated practitioners would be the first to arrive, and so the primary purpose in establishing the Board,—that is, the protection of the public—would be defeated. A limited reciprocity, extending the privilege of the state to practitioners residing in contiguous territory has been considered, but does not seem at present to be feasible. In a recent conversation with the Governor, he stated that should nominations for vacancies be made by this Association it would be a very great help to him, and while in no wise binding upon his successor, he had no doubt it would be very acceptable.

I would suggest that a committee of three be appointed to furnish the State Executive a yearly list of ten physicians who, in the language of the law, shall be learned and skilled in the practice and theory of medicine and surgery and that this committee be one of the standing committees of the Association. It would also be well, during the political campaign, to secure pledges from candidates that appointments would be made from such a list. This would no longer work a hardship against other schools of medicine, since their members may become associated with us, and through us with the American Medical Association.

Frequent appeals have come to the officers of the Board for aid in the enforcement of the state laws. The Board is not only willing but anxious to aid in every way, but evidence sufficient to convict must be furnished before a complaint can be made and successfully sustained. The statute states what the evidence must be, and the statutes may be found in the office of any justice of the peace. In almost every case the complaint is coupled with a request that the complainant should in no wise appear in the prosecution, and yet no other means is offered the Board whereby a successful issue can be asured. If the profession will get up a little more back bone, and stand by every complaint, enforcement of the law will be pushed, and its infringement prevented.

It is one of the crowning glories of our profession that educational institutions are in existence in this country where the quality and quantity of the teaching is constantly advancing. The course as now offered by the best schools consists of two years of the hardest kind of laboratory grinding. The courses are taught by men who have a full perspective of the subject taught, and its relations to other medical subjects. They are and must be medical men. The didactic lecture is relegated to a second or third place, and really is of no use except when given in close connection with the laboratory work. It has become more of a laboratory and bedside annex than an independent method of teaching. Many of us recall medical schools where the didactic course was practically the only one followed. The time for such schools is passed, and where they exist they must be discouraged. The bedside study of the last two years in a college course, combined with a small section clinic, has rendered didactic courses largely unnecessary. The laboratory and bedside methods of study being universally accepted as the only proper methods of instruction in medicine, why should the profession tolerate by its recognition or aid, direct or indirect, any school which offers less? Laboratory work cannot be taught by a busy practitioner who steps in for an hour or two daily and trusts to some student assistant for the bulk of the work. Only those schools can teach these undergraduate studies when they are sufficiently endowed to pay and pay liberally for the whole time of medical men specially trained to teach the offered courses. It is a distinct wrong to the public and to the student when a practitioner fails to protest to the aspirant for a medical education, if such aspirant selects a school other than the best. He will be disappointed, inevitably so in this state, for he will fail to pass his examinations from this time on, and none save men trained in the laboratories and at the bedside need apply. The people want *better* and not *more* practitioners. Furthermore, there is no call for a single new medical school. Over 350 are at present listed in Polk's Directory, and of this number, 300 could be spared to the profit of both the profession and the public in general.

During the spring following notice appeared in the daily papers of this city:

"In pursuance of the policy of steadily broadening the scope of the University of Washington, it is proposed to add a medical school. It is not proposed to do this at once, but to give a two years' course in physiology and anatomy now, under the charge of a medical director. Should it prove that a full medical school would bring attendance enough to justify its creation, it will be added later."

Upon inquiry it developed that the regents generally did not understand that any medical school or medical course was in contemplation, but only the teaching of physiology and anatomy to an extent demanded by the intelligent general student. The subject was dropped by the local profession until a few weeks ago when it became known that a course *was* contemplated by the faculty which should be equivalent to the first two years of medicine, and which medical schools would be asked to accept in lieu of the whole or part of the first one or two years' work. The matter was brought before the County Society and as a result a Committee was appointed, jointly by the President of the State Medical Association and the President of King County Medical Society, to express their strong condemnation of such a course. This resulted in the following:

To the Board of Regents of the University of Washington:

At the regular meeting of the King County Medical Society, held in the rooms of the Chamber of Commerce, Monday evening, June 20, 1904, the undersigned committee was appointed to lay before each member of your Honorable Body the following resolutions:

The Society unanimously voted to request that no steps be taken by your Hoonrable Body or the Faculty of the University to offer any course leading to the practice of medicine; for example, such a course as would be represented by "B. S. in Biology, leading to the Study of Medicine," for the following reasons:

First: Such a course must, in the near future, lead to the establishment of a medical department in the University, a course which we are persuaded is not only unnecessary, but undesirable.

Second: An ethical medical spirit cannot be properly inculcated in first and second year students where instruction is given outside of a properly equipped medical school. (See President Musser's address at the meeting of the American Medical Association, at Atlantic City, June 17, 1904, an extract from which is appended.)

Third: None but thoroughly educated medical men are competent to teach any of the undergraduate medical studies, excepting general chemistry.

Fourth: In the best medical schools the teaching of the first two years is conducted by men specially trained and educated for the purpose. Their salaries are high, for they cannot practice medicine and properly conduct their course. The laboratory equipment is special, and the attendant expense prohibitive except in richly endowed institutions, and even in these the schools are operated at a financial loss, no matter what the income may be.

Fifth: There is a distinct tendency among medical educators to eliminate the smaller and inefficient schools, and concentrate all efforts upon the support and development of those which are at present better equipped.

Sixth: It is a distinct wrong to the medical student if he is furnished a course which will not admit him to advanced standing in first class schools after spending a year or two upon his undergraduate work; and no first class medical school will accept the course offered here, for many of them discriminate against schools far better prepared than the University can possibly be.

Seventh: In case the proposed B. S. course is established, graduates from it will be admitted to inferior schools only, which will thus be encouraged in their present detrimental course. Thus a wrong is done; 1st, to the student; 2nd, to the public; 3rd, the whole tone of medical education is lowered; and lastly, the University itself is injured by a lowered educational standing; incurring the opposition of influential people in the state who are favorable to the development of the undergraduate courses *now* established, and feel that they have a right to demand an academic education for their children that shall be strong, well balanced, and well supported financially.

Eighth: The profession of the State of Washington will make it their business to see that no medical school is established in the State of Washington, nor is any such school in contemplation by any body of reputable medical men. Therefore the University authorities need have no fear that the University will be forestalled in the performance of any of its legitimate functions.

Should the representation of these resolutions be considered insufficient, will the Honorable Board of Regents kindly appoint time and place where a conference may be held with the leading medical men of the State before establishing the proposed course?

The adoption of these resolutions was considered necessary, because of the absolute statement made by members of the Faculty that the course proposed was distinctly for the purpose of preparing students for admission to advanced standing in the medical schools, thus eliminating one or two years of a properly equipped medical course.

(Signed.)

F. H. COE,
P. W. WILLIS,
R. SCHOENLE,
Committee of State Medical
Association and King County
Medical Society.

Each member of the Board of Regents resident in the city was seen and the matter fully explained. Inasmuch as there is to be a meeting of the Board on the 22nd of the present month, I would suggest that this matter be fully discussed here today, and some decisive action taken to furnish the gentlemen with as complete an exposition of our standing in the matter as can be framed. It is further proposed that a committee be appointed to draft a law for presentation to the next session of the legislature which will vest in the State University and in the University alone, all medical teaching, if at any time such teaching is demanded by the best interests of the public in general. The fact that fifteen or twenty men think they want to study medicine, and are sure they want to get it easily and inexpensively, is no reason for establishment of a school. It would be well for the committee, if appointed, to forward a copy of its proceedings to the legislative committee of the American Medical Association and ask its cooperation in securing the passage of such a law in all of the states, thus forestalling any further multiplication of cheap and inefficient schools.

Of course the narrow-minded and bigoted will charge that it is a desire to limit the output and decrease competition in medicine, but this need give no concern to a profession which has ever shown its public spirit and true philanthropy by its efforts to alleviate suffering, to discover the causes of disease, and to its own pecuniary loss, not only assist in their removal, but often accomplish this result in the face of the most stubborn opposition. Where is the man in our profession who does not glory in the work of Jenner, in the magnificent therapeutics of immunity; the plague of diphtheria is all but eliminated; malaria, formerly the most common of diseases, may now be avoided through following the teachings of our eminent investigators; the deadly bubonic plague is watched, studied, and combated by medical men. Where, I ask, is the selfishness of the medical profession seen in these, or any other work, undertaken by it?

Finally, allow me to direct your attention to the latest and the greatest of these public benefactors who have in all time wrought glory for our profession, and brought blessings to the community at large. I refer to Surgeon-Major Walter Reed, who died November 23, 1902. Those who have no knowledge of his wonderful work may find its details in the medical press of 1900, or in the Memoir published and distributed by the Walter Reed Memorial Association, Washington, D. C. A brief summary of his work is all that could be given at the present time, and I must be content with the statement that yellow fever, with its load of agony, and its fearful pecuniary loss, will never again devastate our coasts, and that the greater blessing that has come to the Republic of Cuba, and to the tropical world in general, came at the hands of an humble but honored member of our profession. During his life Walter Reed was honored by degrees from the leading universities of the land as a token of their appreciation. Advancement in rank was granted by Congress. It is proposed that a memorial be erected in the national capitol which shall remain forever a tribute from a grateful profession to one of its successful and unselfish workers. Each member of the Association will receive by mail a copy of the memoir, and I trust that Washington will do herself an honor by contributing liberally to this memorial.

Many of us viewed with grave doubt the appearance of a medical journal in this state, thinking the time hardly ripe on account of the limited number in the profession, and a question as to whether sufficient material in quantity and quality could be obtained. Northwest Medicine has ably proven its right to occupy a place in the journalistic field. It was made the official organ of this State Association, and I have requested its editor at some time during the present meeting to lay before the Association the scope of its work.

The work done by the State Board of Health during the past year, has been the most efficient in its history, and I wish here to bespeak for it the earnest support of the entire profession.

At the time of the adoption of the present Constitution and By-laws of this Association it seemed best to materially deviate from the document furnished by the American Medical Association, but as time passes it is becoming more impressed upon the profession that we can and should more closely follow its suggestions. The effort made by the National Association to unify professional interests, is worthy of every support. I have appointed in each county of the state, and in some cases made two appointments, of members to serve on the auxiliary legislative council. It is the duty of these men to watch and influence medical legislation in the State Assemblies, and to assist the central committee of the Association in influencing national legislation.

ORIGINAL CONTRIBUTIONS.

THE CLEAN MILK PROBLEM.*

By Kenelm Winslow, M. D.
Secretary Laboratory Committee.
SEATTLE, WASH.

From an hygienic standpoint the importance of a clean milk supply surpasses that of any other food or drink. Unclean milk may be—and often is—a deadly poison. Clothed in some seductive name—as for example purporting to emanate from a Clover in their milk.

This amount is probably exaggerated, since Berlin is said to furnish its inhabitants but 300 pounds of cow-dung in its daily milk supply and—allowing a wide margin for our native progressiveness—we could hardly be credited with beating the Germans so tremendously in this international filth contest. It is a most surprising situation that, until recently, our endeavors have been almost entirely directed toward the prevention of adulteration of and beauty of the country, while in truth acting as a medium for Blossom Dairy—it comes into the house suggesting all the health the supply of feces, filth and germs. It has been estimated that the citizens of New York eat daily ten tons of barn filth and refuse milk—in one way or another—when the importance of this matter is infinitesimal compared to that of preventing the bacterial infection of milk. While a milk poor in quality means a loss of nutriment and of money to the consumer, how truly insignificant is this fault compared to the sale of a virulent poison in place of the most valuable of foods. For cholera infantum has long been recognized as an acute milk poisoning—the symptoms indeed resembling poisoning by white arsenic or some similar, violent, gastro-intestinal irritant.

But germ-laden milk combines the properties of being both poor and poisonous, and this is not generally recognized even by the medical profession. The growth of bacteria in milk extracts from it much nutriment, so that an infected or dirty milk twenty-four hours old has much less nutritive value than a clean or fresh milk.

Paradoxical as it may sound, the most dangerous adulterant of milk is probably water—as it often is dirty water and may contain pathogenic bacteria. Most of the chemical adulterants are harmless compared to bacteria in milk. Experiments conducted for two years at the agricultural department of the United States show that milk containing a 1 to 10,000 solution of formaldehyde is more readily digested by calves than is pure milk. Again it has been asserted by recent authorities that the mortality rate among infants is much lower where formaldehyde has been used—on the sly—than where stringent laws are enforced. Furthermore, Rosenheim and Tunnicliffe report no injury to the general health of babies fed on milk containing 1 part of formaldehyde in 5,000 of milk—a solution 5 to 10 times as strong as that commonly used by milkmen. While personally not believers in the use of chemical preservatives in milk, we think that their employment is preferable—at least in the case of formaldehyde—to the use of germ-laden milk.

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*Read as a report of the Laboratory Committee, King County Medical Society, before the Washington State Medical Association, Seattle, Wash., July 12, 13 and 14, 1904.

The danger of unclean milk is not by any means confined to that of causing diarrheal diseases of children—although responsible for from 20 to 60 per cent. of infant mortality in various localities—but there are many other special diseases of men and cattle which are transmitted through the medium of milk. While the controversy rages as to the degree of transmission of bovine tuberculosis to man by milk, little is known concerning the effect produced upon the human by toxins elaborated by tubercle bacilli in milk.

A significant phenomenon is that produced by injecting milk containing tubercle bacilli into tuberculous animals, whereby a reaction is displayed similar to that caused by the injection of tuberculin. Milk secreted by cows suffering from mastitis may cause not only gastro-intestinal troubles in man but—through the staphylococci and steptococci, thus transmitted to the consumer—may lead to stomatitis and infections closely simulating diphtheria and scarlet fever. An endemic of stomatitis, with herpes and glandular enlargement occurring recently in Seattle has come to our notice, which was attributed to milk. Puerperal fever, foot-and-mouth disease, cowpox and anthrax may be communicated from beast to man in milk. Medicines given sick cows, noxious plants and improper food—as swill and fermented brewers' refuse—eaten by cattle, may make their milk poisonous or unfit for food.

Among human diseases conveyed by milk to man, through contamination of milk after it leaves the cow, are notably typhoid fever, scarlet fever and diphtheria. Many of the cases of scarlet fever—and more of the diphtheria cases—are, however, spurious forms simulating the real diseases and due to streptococcus infection of milk within the udder from inflammation of this gland.

Infection of the milk from man arises from the following causes: Because those handling milk are acting as nurses in, or are exposed to, infectious diseases; or are themselves patients with, or are convalescent from, infectious disorders. Again, by wading in filth, cows may contaminate their udders with typhoid bacilli. Water containing typhoid bacilli may be used to wash dairy utensils or may be employed to adulterate milk. Scrubbing cloths and brushes used to clean dairy utensils, flies, and vitiated air also serve to convey typhoid germs to milk.

In 195 epedemics of typhoid traced to milk, 148 arose from typhoid existing at the farm or dairy; in 99 epidemics of scarlet fever, originating from milk there were 66 instances in which the disease prevailed at farm or dairies from which the milk was obtained. And in 36 outbreaks of diphtheria, attributed to milk, 13 of the cases owed their source to that disease occurring at the farm or dairy, and 12 to streptococcus infection of the milk from cows suffering from mastitis.

Seattle consumes approximately some 30,000 quarts of milk daily. Of this amount half is probably Pasteurized, but only for two or three minutes at a temperature of nominally 165° F. This Pasteurization of milk is done after the arrival of milk in the city. The milk at this time represents that milked in the morning of the day of its arrival, which is five or six hours old, and that milked the night before, which is sixteen to seventeen hours old. If milk is left at the door in Seattle before 8 a. m. it must be twenty-four hours old, and in some cases represents milk of thirty-six or forty hours of antiquity.

This happens because all the milk arriving in the city by milk train comes in after 8 a. m., and some of it, as we have already said, is sixteen hours old. This milk is handled in the following manner: Some goes directly from the cars to the consumer; some goes to the dairy, and is there Pasteurized and is then delivered to the consumer the same day or the following morning. The result of this state of affairs should lead milk consumers to renounce the pleasing idea of awakening to find a suppositious supply of fresh milk reposing on the doorstep along with the morning dew, newspaper and other products of the night, but the public should be content to receive milk later in the day when that drawn from the cow in the morning of that same day may be obtained.

Bottled milk is at present either bottled at the city dairy or on the wagon, alley, or sidewalk at the customer's door. The proper place to bottle milk is, of course, at the farm, immediately after it is drawn from the cow, aerated and cooled. At present this is not done. Bottling milk en route should be absolutely forbidden, as all advantages pertaining to this procedure are lost and the disadvantages accruing througt liability to contamination with dust and flies and with dirty bottles just returned from a neighbor —to say nothing of the gratuitous milk tickets which have frequently been found lying in the bottom of the milk—make the practice obnoxious and fraudulent. There is also liability to spread of infection if the bottle used has just been returned from a house in which infectious disease prevails.

Through the kindness of the city Board of Health the services of the milk inspector—Mr. Woodcock—have been put at our disposal and we have made an inspection of some twenty farms extending from South Seattle to a point some eighteen miles from the city and also of some of the so-called city dairies. We will be pardoned if we say here that the city is to be felicitated on its good fortune in possessing the services of an inspector so eager and efficient in his duties as is Mr. Woodcock. It is largely due to his unsleeping vigilance that conditions are not much worse than they are, considering the poorness of our city milk ordinance, which has long outlived its usefulness.

We do not propose to weary you with the horrible details of filthiness we saw further than to describe its most salient features. In no instance were cows kept in a separate stable, but were in a part of the barn openly connected with the main building and having free access to all the dirt and dust therein. In the worst case the cows supplying milk for a dairy, whose name is suggestive of green pastures, were wallowing in manure and urine, while their backs were covered with a heavy layer of dust and hayseed falling down from above, and this in the course of milking. The name of the milk in this instance was further fraudulent in that the cows were fed on brewers' refuse and turned out into a yard to dry their skins occasionally. Everywhere the cows were liberally bespread with their own or their neighbors' dung, and no attempt was made in any instance to clean them, except in one case an overzealous milker, after milking, washed off an unusually manured udder into his milk pail.

The milkers—Swedes and Japs—betook sympathetically of the fecal character of their bovine companions, and their hands especially reveled in its grasp.

The milk, when withdrawn, was invariably strained through cheesecloth into large cans, which were sooner or later immersed in running water of a temperature at the time of our visits in May, of from 58° to 62° F. The troughs containing the cans were sometimes outdoors without covering, and at times in shed-like structures, but in no case in dust-proof or fly-proof buildings.

Only two aerators were seen in operation. An aerator is an essential adjunct to a farm raising milk. It is an arrangement whereby the warm, freshly withdrawn milk is immediately cooled by flowing from a tank over a large expanse of tin cylinder, the interior of which is cooled by running water flowing through coils of pipe.

In the city dairies dirtiness and sloppiness generally prevailed, but not nearly to the extent which obtained not long since, when a pair of horses stood in one so-called dairy and distributed impartially their fecal contributions in the midst of the dairy utensils. The milk in the dairies is subjected to Pasteurization for, strange to relate, only three minutes in most cases, and is cooled at once and placed in vessels in ice water. Pasteurization conducted for this length of time is sufficient to destroy or inhibit the growth of the least resistant bacilli—especially the lactic acid organisms—and is undertaken by the dairymen in self-preservation to prevent the milk from souring. Longer heating, they claim, gives the milk a boiled taste and prevents the cream from rising well. Here in the dairy the cans and bottles are sterilized with live steam, and the clean cans are sent back to the farmer. The interiors of the dairies are entirely of wood, with unscreened doors and windows, while the floors are continually saturated with sloppping ice, milk and water. What with the crowded, whirring machinery running the Pasteurizer, separator and ice cream freezer, the banging and clanging of tin cans, and the general sloppiness and dirt, one fails to recognize one's ideal of a dairy in this hermaphroditic combination of a machine shop and a laundry.

The state of the wagons and of the individuals presiding over them is a matter of common knowledge. The driver of the Seattle milk cart does not wish his fellow worker on the garbage chariot to suffer any humbling sense of inferiority through invidious comparison, so that he often assumes the same garb or garbage costume and general aspect as the swillman. And, finally, we come to the consumer himself, who cannot escape a generous share in the indictment of aiding and abetting the milk producer and vendor in causing deterioration in the milk after it is left in his care. The milk is often received in a dirty pitcher or lard pail, and in a great percentage of cases remains exposed to air and dust without the use of any ice for its preservation. Under such circumstances is it fair to complain, or rational to appear surprised, that a milk containing millions of bacteria to the cc., already twenty-four to thirty-six hours old, will not keep sweet another twenty-four hours?

Here let us say that, notwithstanding the coolness of the climate, the absence of cheap ice constitutes a great drawback to the proper handling of milk in warm weather. In several Eastern cities—as in Boston and New York—milk is confiscated when found to possess a temperature above 50° F. Mr. Woodcock, at our request, has kindly been taking temperatures of milk on its arrival in Seattle and on the delivery wagons, and finds it varies greatly with the weather, etc.

While the milk during May, when we took our temperatures at the farms, was cooled to 60° F. or thereabouts by running water, and in the dairies is cooled in ice water, it is not cooled after leaving the farms until it arrives, some hours later, in the dairy, nor while in transit from the dairy to the consumer, except in a few cases where ice is now carried in the milk wagons.

The two essentials in the production of pure milk are cleanliness and cold—immediately chilling of the milk to 36° or 40° F., and the maintenance of this temperature thereafter. When neither of these conditions can be fulfilled, what can be done about the matter? Or, to put it in another way, the question resolves itself into this: "Given dirty milk, how shall we make it wholesome?" But the query naturally arises, "Is it necessary to have dirty milk?" We believe that for a long time it will be unavoidable, as the dirtiness begins at the farm, and no amount of supervision and cleanliness afterward will wholly counteract it. There will be required, to remedy this state of affairs, state supervision of the farms; or, what we feel convinced is the most immediately practicable plan, is that in force in Vancouver, B. C., where the city milk-seller cannot obtain a license unless the farmer from whom he obtains his milk agrees to submit to inspection, and if the results of such supervision are not satisfactory, the trouble is removed by taking the license away from the seller in the city.

Another partial mode of relief presents itself. This consists in the King County Medical Society offering a certificate to anyone supplying a pure milk which shall pass its laboratory requirements as to chemical composition and bacterial contents. The standard might be that of the commission of the New York County

Medical Society—not to exceed 30,000 germs to the cubic centimeter. This is, of course, an unusual degree of purity, as in Philadelphia there are but six dairies which can conform to this standard and but a few in New York; while in New York the average of bacteria to the cubic centimeter is about five to six millions, and is about the same in Seattle.

The milk should be brought into the city in glass bottles from the farm, surrounded by ice in warm weather, and should be delivered to customers in the same condition. To obtain such milk certain requirements are essential. The cows must be healthy and should be examined by a veterinarian and tested by tuberculin; the workmen should also be subject to medical supervision to exclude tuberculosis and infectious diseases. The cows should be kept in barns devoted exclusively to them, with cement floors, gutters and walls; well lighted and ventilated. The stable should be frequently washed with a hose, the cows should be well-groomed and their udders washed and dried with sterile towels before each milking. The milkers must be scrupulously clean and wear sterile outer clothing.

The milk utensils must be sterile, and the milk cooled at once to 36° F. in the dairy and placed in sterile bottles on ice. Such milk should also be richer than ordinary—the fat exceeding 4 per cent. and preferably reaching 5 per cent. by admixture of Jersey blood. The milk room should be completely cemented—walls, ceiling and floor—and so ventilated that open windows or doors shall not be requisite. Such conditions are not mere figments of the imagination, nor do they entail great expense, for such obtain in many farms in this country. In the Brookside farm, in Newburg, New York, milk is produced according to the plan outlined and is sold at 8 cents, without, it is true, much profit; but at 10 cents it would pay a good profit. The bacterial contents of milk from this farm runs below 2,000 germs per cc., and on several occasions no bacteria whatever were discoverable.

There are now some persons who have expressed to us their desire and ability to build the necessary plant and to produce clean milk for Seattle if they can be but convinced that there is a sufficient demand for a reasonable amount of clean milk which may be certified by this society and sold for 10 cents a quart.

Now we come to the proposition—given a dirty milk how to make it wholesome. Pasteurization and the addition of antiseptics may, to a certain extent, obviate the dangerous properties of infected milk.

We will consider, first the pros and cons of Pasteurization. To begin with, Pasteurization is undesirable in offering a cloak for slovenliness, and, if generally adopted, may inhibit or prevent progress towards a clean milk supply. Then as regards the effect of cooked milk upon children, we have the results of the investigations of the American Pedriatric Society, which showed that out of 370 cases of infantile scurvy 20 patients were reared upon raw milk, and 107 had been fed upon sterilized milk.

Whether Pasteurization as conducted at the dairies hereabouts for so short a period as three minutes would be equally pernicious is questionable. Pasteurization will not destroy tyrotoxicon or other toxins already formed in milk, and should, therefore, be preferably employed at the farm as soon as the milk is withdrawn. The least resistant organisms destroyed by Pasteurization are the lactic acid bacilli. the coli and proteus groups, and it is probable that these are chiefly responsible for summer diarrheas of children, for the spore-bearing bacilli are not killed, nor are tubercle bacilli. Cocci are, however, destroyed by Pasteurization.

To be efficient, Pasteurization should be continued for half an hour to certainly annihilate even the non-spore-bearing bacilli, although it is remarkable how marked is the immediate reduction in bacteria following the sort of Pasteurization used in Seattle, as shown by our experiments. Another drawback to Pasteurized milk is its greater liability to favor the development of rickets in babies. It has been shown experimentally that children fed on sterilized milk do not absorb lime salts as well as from raw milk.

We shall now proceed to consider the results of our bacteriologic examinations of milk sold in Seattle. It must be remembered, however, that this work was done at that season of the year when the milk might be expected to be in the most cleanly condition. For in June, when we made our tests, the cows are as pure as new fallen snow compared to their filthy state during the rainy season, when they are plastered with mud when turned out, only to be replastered with manure when they return to their indoor quarters.

In our experiments, which have extended for but four weeks or so, we have depended chiefly on the kindness of Dr. Lazelle, who has spent much time in the preparation of nutrient media, in sterilization of all the bottles for gathering samples of milk, in diluting the milk and making the plate cultures. The milk inspector, Mr. Woodcock, has shown the greatest interest in the work and has, owing to the friendly co-operation of the city Board of Health, aided us in every possible manner.

Our object has been simply to determine the amount of bacterial infection of milk and the various causes influencing the degree of infection. The general method of examination has been to dilute milk with liquid agar and to grow colonies in Petri dishes at room temperature. Within twenty-four hours or thirty-six hours the colonies may be counted with the aid of a hand lens and the number of bacteria calculated. As far as we know, Boston is the only city which has a legal bacterial standard for milk; the new rule providing that no person shall bring into Boston for sale any milk which contains more than 500,000 bacteria per cc. or which has a temperature higher than 50° F. If these provisions were enforced in Seattle at present the milk supply would be cut off completely.

The temperature has been taken in some thirty to forty samples of milk at the farm when ready for delivery; at the arrival of the milk train, in the dairies and on the milk wagons—by Mr. Woodcock. The lowest temperature has been 53°; the highest 70° and 72° in two cases. These latter occurred in milk coming into Seattle, from which the animal heat had not been removed by cooling. In about one-half (16) of the samples (33) was the milk below 60° The temperature was invariably above that which has been found desirable, and as the same milk is subjected to various temperatures during its transit from cow to consumer there was not any special relationship noted between the temperature of the milk, when the sample was taken, and the bacterial content.

Dr. Lazelle began by diluting the milk with only 10 parts of sterile water, but we soon found that a dilution of one part milk to 500 parts of water was necessary to enable us to count the colonies in many cases, so plentiful were the bacteria. To give you an example of the degree of bacterial contamination: In twenty-eight successive examinations, sixteen samples contained over 3,000,000 bacteria to the cc., and twelve samples contained less than 1,000,000 to the cc. of milk.

The Seattle milk appears to resemble the little girl of the nursery rhyme—

"When she was good she was very good indeed,
But when she was bad she was horrid."

The bacterial count is apt to be in the millions or billions or considerably below the half-million mark. The cleanest milk has generally come from farms within or near Seattle and represents the so-called private dairies in that, supposedly, they are more exclusive as regards bacteria. As a fact, such milk, being more quickly delivered, would naturally contain fewer bacteria when examined by us when it was a few hours old, as compared with the milk coming from a distance and being in part that milked the day previous. To exhibit the difference between night and morning milk we received two samples of one of the cleanest milks we have examined—one sample was milked the previous night, and one on the morning of the day of examination; the night's milk contained 120,000 bacteria; the morning's milk only 26,000 bacteria to the cc.

We have been particularly interested in the results of the examinations of milk as Pasteurized by the dairymen, for three minutes at 165° F., which they do to keep their milk from souring. When this milk emerges from the Pasteurizer it may contain as few as 15,000 bacteria, but within twenty-four hours—when delivered—the count shows the bacterial content has risen to the millions. This method of so-called Pasteurization for three minutes at 165° F. is a snare and a delusion so far as making sterile milk is concerned. This short cooking—while arresting the growth of the least resistant bacilli, especially those causing lactic acid fermentation and souring, merely lessens the degree of infection for a short time when the milk is not cooled below 50° F.

Another reason why milk is not cleaner, which has been thus Pasteurized, is because it is exposed to dust and unclean utensils in the handling. For example, a sample of Pasteurized milk taken from a delivery wagon showed a bacterial content of nearly seven million to the cc. This milk was in a large can which was frequently opened to pour out small quantities for consumers, and very likely the can was unclean in the first place. From the same wagon was taken a sample of the same milk, which was also Pasteurized, but was put in a sealed bottle, and only gave a bacterial count of 24,000 to the cc.

To contrast the three-minute Pasteurization of the dairymen, with that as commonly done by the medical profession, we Pasteurized in the laboratory a milk some twelve hours old—and containing 672,000 bacteria—for twenty minutes, at 165° F., in a sterile bottle and left the bottle at air temperature and sealed, standing outdoors for nineteen hours, when the milk proved absolutely sterile. To test the efficacy of Freezine (a 5 per cent. solution of formaldehyde and the most popular commercial preservative) we added a sufficient amount to make a 1-50,000 solution of formaldehyde in milk, when, after standing 3½ hours, the milk gave a count of 39,000 bacteria, as against 320,000 in the same milk to which no formaldehyde was added.

Formaldehyde was added to another sample of milk, enough to make a 1-25,000 solution, which is twice the strength commonly used and directed by the makers of Freezine, and this milk, after standing for twenty-four hours at the same temperature at which our Pasteurized milk remained sterile, showed a content of some 800,000 bacteria to the cc. This same milk, without formaldehyde, it is only fair to state, would have probably given a count up in the millions.

To demonstrate how easy it is to secure clean milk even under unfavorable conditions we asked Mr. Woodcock to milk some milk from a bovine neighbor of his into a sterile bottle. The milk used as a sample was the first few ounces stripped from the udder, which is most apt to be infected and which, on this account, is often thrown away. But the milk was clean, the cow was clean and the milk pail was clean, and it turned out that the milk was clean, for on standing at room temperature for ten hours, after being cooled following milking, it showed but 20,000 bacteria to the cc., and was as good as milk sold by the most fancy farms in the land.

We will now return to our problem, how to obtain clean milk. We give it as our opinion that there is only one way, and that is to make it at the farm. Adulteration with chemicals is a fraud, and is only partially effective, while the so-called Pasteurization of the dairymen is also a fraud, in that it does not fulfill the the requirements of the meaning of the term as applied to milk in regard to the duration of the operation, and therefore fails in accomplishing what proper Pasteurization will do. True Pasteurization is of value, but may be performed by the consumer when desirable.

Even the inefficient three-minute Pasteurization done by the dairymen could be more properly performed at the farm. A sample of milk which contained 20,000 bacteria we heated to 165° F., immediately after it was milked, for thirty minutes, and then cooled, and we found it to be sterile compared to the same milk which was not heated and kept for the same period twelve hours. To hastening the coming of that time when it may be possible to secure a general supply of clean milk in Seattle, your committee would make the following suggesstions:

1. That a committee be appointed by the King County Medical Society to confer with the Board of Health of Seattle and formulate a new city ordinance governing the care and sale of milk in Seattle.

2. That in the new ordinance shall be required licenses of all dairies, shops and wagons from which milk is sold.

3. That to obtain such licenses the applicant must not only submit to inspection himself, but must supply a written agreement from the farmer or milk seller from whom he obtains his milk that the farmer or milk seller will also agree to inspection by the agents of the city Board of Health. This provision, which is now in force in Vancouver, B. C., will bring under the control of the city Board of Health the farmers who are now without their control and who represent the fountain head and original source of dairy milk.

Moreover, the cost of the license should defray the expense of the extra inspectors which would be required for proper supervision. Then if the conditions at the farm were unsanitary the Board of Health could correct the fault by stopping the sale of the milk in the city.

4. That licensees and milk vendors should be compelled to report cases of infectious diseases occurring among those who handle milk for sale.

5. That milk above 60° F. should be condemned. This temperature is altogether too high, as 50° F. is the standard set by Boston and New York, but it is believed that the proper standard would be impossible to enforce at present and that of 60° would prevent the delivery of milk from which the animal heat had not been expelled.

6. That the licensees of dairies, wagons and shops not complying with the requirements as to cleanliness, including such features as cement floors and screened doors and windows in dairies, should have their licenses revoked by the law.

7. That bottling of milk be forbidden except at the farm or city dairy.

8. That if milk is Pasteurized it should be required that the consumer be notified of the fact, including the temperature and duration of the process, by means of labels on the bottles or otherwise.

9. That milk tickets be destroyed after they are returned from

the consumer and not passed about from one person to another, thus offering an opportunity for the spread of infectious diseases by this means.

These embody in a general way the chief suggestions we would make for the consideration of a committee framing a new ordinance. We do not believe that the time is ripe for a bacterial standard, but if such a standard is not legally declared the results of a bacterial count should practically be of service to the milk inspector in enabling him to condemn milk which is especially dirty. At present it is necessary that the inspector powerfully perceive by means of his eyes or nose that milk is dirty in order to confiscate it, and then he runs the risk of involving the city in a lawsuit by so doing. In future the scientific accuracy of a bacterial count will be sufficient to protect the inspector and city from legal damage.

In closing perhaps the laboratory committee may be pardoned for stating that in its estimation the duties of a laboratory conducted by a medical society should not be confined solely to performing routine work for which it is paid, but the energies of such laboratory should, so far as possible, be used to aid in every way the prevention of disease and the promotion of general hygiene in the community. The laboratory, furthermore, should be a means of promoting scientific interest in the society, and the society, in its turn, should regard it as their choicest offspring and should cherish and encourage its growth accordingly.

In this slight contribution it has been the aim of your committee to initiate a beginning of scientific work in the laboratory of the King County Medical Society with the underlying ideas just stated, and we trust that it may not be the end.

NORTHWEST MEDICINE

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Editor in Chief.

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THE SEATTLE MEETING OF THE WASHINGTON STATE ASSOCIATION.

This was commonly recognized as the most successful meeting in the history of the Association. The attendance exceeded that of any previous occasion; the program included papers by more members and visitors than ever before and a universal spirit of good fellowship and harmony prevailed. Mayor Ballinger struck the key note of the spirit of the whole meeting when, in his address of welcome, he touched on matters peculiar to the medical profession that are also of vital interest to the body politic. He called attention to the abuses that prevail in all the cities of our state. the correction of which rests largely with the physicians as leaders of public sentiment. The proper care of the destitute sick, the elimination of medical fakirs and blood-suckers, the elevation of the tone of the medical profession are thus seen to be subjects not confined alone to the minds of those personally interested in them.

Likewise the President's address dealt with matters of wide reaching import. intended for much larger purpose than the mere entertainment of the Association. The address, as published in this issue. is worthy of the attention of many readers. This same educational spirit pervaded many papers and subjects under discussion, notably those pertaining to clean milk and venereal prophylaxis, both matters of which the general public are deplorably ignorant. We are pleased to state that the agitation of the milk problem, as published in the daily press, has caused a decided sensation and resulted in action on the part of the Seattle authorities that will produce results. We trust that the same may be said of other cities of the state in the near future.

The length of program necessitated evening sessions which have not heretofore been held and which were introduced with hesitation. But the result justified the innovation since the largest attendance was in the evening. This custom is especially convenient for the local profession, many of whom imagine they cannot leave their offices during the day but appear in numbers at night. This was not true of a large portion of the Seattle physicians, however, many of whom were present at every session.

This meeting has proven again that it is possible to hold satisfactory meetings of our State Associations and rely upon local talent for the literary and scientific entertainment. In consequence of a series of unfortunate circumstances one after another of the distinguished physicians from the East, who promised to attend the meeting, were prevented from so doing. In addition to the productions of Washington men the success of the meeting was largely due to the able support provided by the Portland visitors in the way of papers and interesting discussions. Without them a meeting of this Association would not be complete. We take this occasion to express our indebtedness and appreciation of the assistance of Drs. Hutchinson, Coffey, Williamson, Coe and House. These interchanges of visits are to be encouraged as fostering friendship and union between the professions of the two states that are otherwise scarcely possible.

The successful outcome and momentum of each session was due to the untiring diligence and constant attendance of President Coe, who always called the meeting to order at the fixed hour, promptly stirred the members to the discussion of points of interest, and checked those who transgressed their allotted time for speaking.

The social features were well attended to. Entertainment was provided that occupied most of the time not devoted to the regular program. The reception and luncheon at Dr. Coe's residence, on Wednesday noon, was a great success. The beautiful setting of his home, overlooking Lake Washington, surrounded by a most luxuriant natural growth of trees and shrubbery, was a delight to the ladies and gentlemen, who were present in large numbers. The cordial greeting of President and Mrs. Coe to the swarm of guests was a happy introduction to a pleasant afternoon in the open air. While the President had difficulty in calling the members together for the afternoon session on his west lawn, the feeling prevailed that the time had been profitably used. The reception and tea at the Firloch club, on Thursday afternoon, was likewise largely attended by the ladies and members of the Association and the guests. The proximity to the lake, with the mountain views beyond, makes this a most attractive situation for such a gathering. These two affairs will be remembered as most pleasant occasions on account of bringing together so many physicians and their wives for mutual acquaintance.

The smoker and supper at the Washington was universally declared to be a fitting climax to the most successful meeting in the history of the Association. All parts of the state were represented. The informality exhibited made everybody feel at home and the best of good fellowship prevailed. Dr. Peterkin, as chairman of the reception committee, had something doing all the time and proved himself in his element while presenting his collection of vaudeville artists. The change from a long course banquet to a supper, about a number of small tables, was pleasing and acceptable. Songs and a few informal speeches, interspersed with anecdotes, helped to put all in good humor. President Coe and President-elect Yocum were recipients of ovations that testified to the regard in which they were held by their associates. The evening ended with the confidence that this would long be treasured as a most memorable meeting of the Association.

NORTHWEST MEDICINE AND THE STATE ASSOCIATION.

At the Spokane meeting, last year, it was voted to make Northwest Medecine its official organ. While the custom is exhibited, in many states, for each Association to establish and publish its own journal, the comparatively small size of the Washington Association will preclude such a step for some years to come. In the meantime, Northwest Medicine will aim to take the place of such a publication. Our purpose is to present to each member a report of the transactions of the Association meetings and, from time to time, any important information that may arise, of which the members should be informed. The papers will be presented in suitable issues, during the year. It is not the policy of the journal to place the members on the subscription list unless paid subscribers. Therefore, the papers will not reach all the membership if they are not such subscribers. We take this occasion to solicit subscriptions from all physicians of the state who are not yet with us. We feel that this journal is an agency which can be made mutually helpful to the whole profession as a means of intercommunication, if it is received generally and all feel that they have a part and interest in its success and maintenance. We shall welcome suggestions and criticisms from our readers, as we desire to present a journal that will accord with their ideas of what is best and ethical in this form of publication.

MEDICAL NOTES.

The Attendance and Visitors at the Seattle Meeting. At every session a good sized audience was present to listen to the reading of papers and each received some discussion, some eliciting warm interest. The registration list contained 177 names. The following were from cities other than Seattle: From Tacoma, J. R. Yocum, A. DeY. Green, Chas. McCutcheon, P. B. Wing, Warren Brown, H. W. Dewey, J. W. Bean, G. H. McGreer, J. W. Moore, P. H. Harrason, C. H. Kinnear, F. R. Hill, Grant Hicks, J. J. McKone, J. B. McNethney; from Everett, J. R. Hedges, J. S. McIlhaney, H. P. Howard, C. A. Mead, J. F. Manning, J. S. Newcomb, W. S. Durand, W. F. West, B. L. Baker. W. C. Cox; from Spokane, J. M. Semple, W. S. Hall, A. H. Coe, W. M. Potter, G. W. Libby, W. M. Newman; from North Yakima, H. R. Wells, C. J. Lynch, P. Frank; from Bellingham, H. Thompson, L. R. Markley, W. D. Kirkpatrick; from Ballard, M. L. Adams, S. J. Bridenstine; from Colfax, W. Johnston, T. D. Ferguson; from Snohomish, N. S. McCready; from Roslyn, E. Mohrmann; from Monroe, L. L. Stephens; from Sumner, J. H. Corliss; from Waitsburg, H. A. Mount; from Elma, E. P. French; from South Bend, G. W. Overmeyer; from Wenatchee, H. A. Saunders; from Sedro-Woolley, C. C. Harbaugh; from Stanwood, O. R. Allen; from Friday Harbor, G. S. Wright from Port Townsend, H. C. Willison; from Enumclaw, H. H. Rust; from Cle Elum, I. N. Power; from McMurray, A. R. Gould; from LaConner, G. E. Howe; from Goldendale, H. T. Hartley; from Portland, Ore., Woods Hutchinson, Wm. House, H. W. Coe, W. T. Williamson, R. C. Coffey; from Toledo, Ore., Thos. Parker; from Lewiston, Idaho, J. B. Morris; from Oakland, Cal., J. H. Neagle; from Minneapolis, F. A. Klenert; from St. Louis, I. A. Weichbrod; from Canton, Ill., J. E. Sutton; from Chicago, E. E. Grant; from Boston, E. W. Shend; from U. S. Navy, A. R. Alfred; from U. S. Marine Hospital, J. W. Amesse.

Changes in the By-Laws. A number of alterations were introduced that the committee in charge of this matter believed would facilitate the work and usefulness of the Association. They will be appreciated when the amended Constitution and By-Laws are in the hands of the members. We wish to call attention to the added clause of the duties of the President. This is to the effect that, during his term of office, he shall visit each County Society, the expense for which shall be borne by the treasury of the Association. If properly carried out, this provision will result in building up the organization throughout the State and especially adding strength to the smaller societies. Closer relations can thus be made to exist between the individual societies and the parent State Association, through the personality of the President, who, for the time being, is the most prominent member of the profession in our state. This seems a timely and important modification.

Canadian Medical Association. This meeting has been well advertised before the profession during recent weeks. It will be many years before it again assembles on this Coast. Therefore it will be fitting that many accept the opportunity of attending it. It is reported that a large delegation has been assured from Seattle, Tacoma and Portland.

The meeting will open at 10 a. m. on Tuesday, Aug. 24. Mr. Mayo Robson will deliver an address on Surgery. Dr. C. E. Dudley will deliver an address on Gynecology. There will be numerous papers by men of prominence from Eastern Canada, United States and Great Britain. Entertainments and excursions have been arranged to many points of interest that will attract the physicians in attendance and others will be specially provided for the ladies during the time when meetings are in progress.

Oregon State Medical Society. This society will meet in Portland, Aug. 30 and 31. The guests of the society from the East will be Drs. Harold Moyer, of Chicago, and Charles J. Mayo, of Rochester. In addition to papers by the members from Oregon, the program will contain contributions from Drs. H. D. Niles and S. C. Baldwin, of Salt Lake; P. W. Willis, of Seattle; G. S. Hicks, of Tacoma; Sherman and Huntington, of San Francisco; Maxey of Boise.

Following immediately after the Canadian meeting, undoubtedly prominent men from the East will attend this meeting and help to make it one of especial attraction and interest. We trust a spirit of reciprocity will be exhibited by the Washington profession and that they will be present in as good a representation as we received from Oregon last month.

The A. M. A. Meeting for 1905. As the facts appear concerning the Portland meeting it shows very excellent and careful work on the part of the Oregon delegates at the Atlantic meeting. In view of the opposition and counter inducements from other cities desiring the 1905 meeting, they are entitled to hearty congratulations for their success. It will be advisable to keep the Portland meeting constantly before the physicians of the Northwest. It is a great undertaking for this section of the country. Already the croakers begin to predict its failure and, since that word is not known on the Pacific slope, it is necessary to begin work at an early date. The Portland authorities are discussing the erection of a special auditorium for use at the Fair and for the man gatherings of large numbers of people during its course. This will assure a suitable meeting place for the Association. An abundance of accommodations and entertainments are in contemplation already that prove the Portland physicians are alive and awake to the opportunity. We anticipate nothing but a great success in this endeavor.

TO OUR READERS AND CONTRIBUTORS.

All material for publication must be received by the twentieth day of the month preceding a given issue. Articles will be illustrated by half-tones or etchings when accompanied by photographs or drawings for the same. Reprints of contributed articles can be obtained at the cost of publication, from the Metropolitan Press, publishers of the Journal. A limited number of additional copies of the Journal will be supplied to contributors, if a request is made for them.

TO ADVERTISERS.

We wish to call attention to the fact that **Northwest Medicine** has no department for reading notices, publishers' notes, etc., and that the literary and advertising pages are entirely distinct.

OBITUARY.

DR. FRANTZ H. COE.

The sudden death of Dr. Coe, twenty-four hours after his cheerful and happy services as presiding officer of the State Association meeting, came as a shock to all, even to those most intimately acquainted with him and familiar with his condition of health. He died in uremic coma, in the early morning of July 16, after a few hours of unconsciousness following a day of unusually close application to professional work.

He was descended from vigorous puritan ancestors through both parents, the first settlers in this country, arriving in 1636 and locating in Connecticut. He was born in St. Charles, Ill., Nov. 25, 1856. He lived here till the age of ten, when the family moved to Beloit, Wis., remaining there till the fall of 1872. Then he moved to Ann Arbor, Mich., where he entered the junior class of high school. This was followed by the course at the University of Mich., from which he graduated in 1879, at the age of 23. In the fall of this year he was appointed principal of the public schools at Phenix, Mich. In the summer of the following year he was married to Carrie Everett, at Chelsea, and returned to Phenix for another two years of teaching. In 1882 he moved to Menominee, being principal of the schools of that city until 1884.

During the last three years of his college course he devoted time to subjects preparatory to the study of medicine, having always in view his future entrance into the medical department of the University. During his five years of teaching this aim was not forgotten and he did work leading to this end. He entered the Medical Department of the University of Michigan in the fall of 1884 and received his degree in 1888. For one year during his course he was Assistant Demonstrator of Anatomy and during another year he assisted Dr. Frothingham, professor of opthalmology. During several summers he attended to the practice of different physicians in Northern Michigan.

After graduation, in 1888. he decided to settle for practice somewhere in the West, and during that summer started on a prospecting tour. He first stopped at Denver to visit friends and inspect the city. Next he investigated Salt Lake City. He came to Seattle by the way of San Francisco and Portland, having been attracted by what he had heard of this city. He reached here in the fall of that year and very soon decided to make this his future home, sending shortly for his family.

He at once took offices with Dr. Weed, one of the oldest physicians of the city, in the Yesler-Leary building, situated on the present site of the little green plat of grass, on Pioneer Square. Like all the other physicians of the city, he was burned out of his office by the fire of the following year, and for a time he and Dr. Weed had offices in the latter's residence, on First Avenue, near Union Street, adjacent to the Weed House. His intention at first was to make a specialty of diseases of the eye, ear, nose and throat, but after a few years abandoned this for general practice. He has attended constantly to professional work for the past sixteen years, with few interruptions. During 1895 he spent seven months in the East on account of serious illness in his family. This period was one of profitable study at the medical schools of Ann Arbor and Detroit, and he always felt himself an abler physician for these months of eastern work. Again he was forced to abstain from professional work during the winter of 1898-1899, when an acute attack of nephritis developed which kept him from practice for about eight months, a part of this time being spent in California, where he sought restoration to a normal state. He plunged again into activity of practice with the vigor of a man in the best of health and strength. During the past six years he has been in the condition of a man working on top of a volcano that may at any time overwhelm him with an eruption. In order to avert this threatened calamity he submitted to the operation of decapsulation of the kidneys, fourteen months ago, at the hands of Dr. Edebolils, of New York. His improved health since that time has been attributed to this and it is believed his life was thereby materially prolonged.

The strength that he displayed and the influence he exerted for the elevation and improvement of the medical profession, has not been fully appreciated. From the outset of his residence in this state he has striven to eliminate what was false and partook of imposture on the part of medical practitioners. For this reason he has labored for legislation that would regulate medical plactice in the state and, by his work in connection with the Examining Board, has endeavored to introduce the best class of physicians. And this has not been for selfish purposes. He adopted a broader view than the personal one and believed that, since the medical profession is a leader and teacher in so many public and private matters, it should comprise upright and learned men and women. His usefulness in this field was recognized by the Governor of this state, who recently re-appointed his as a member of the Examining Board. Being a man not only of thorough education himself, but also a practical instructor, he was vitally interested in the matter fo medical education in this state. During recent months he has been a leader in the discussion of this question and, by his thorough grasp of the subject in all its bearings, has exerted a marked influence in directing intelligent thought concerning it.

He always evinced a lively interest in the latest advances in his profession, being better posted in the details of recent scientific progress than most physicians of his years and equally so with many of the recent graduates in medicine. He accomplished this largely by an active perusal of the latest medical literature and by the careful and methodical keeping of a card catalogue of medical writings, a very unusual procedure on the part of physicians. Those who knew him well can recall many instructive and entertaining discusssions on recent scientific investigations that testified to his keen, attentive observation of the new fields opening to medical research.

He served for two terms as a director of the Seattle public schools and in that capacity was of great service in placing the schools on a high plane of efficiency. By his aggressive and forceful character he was a natural leader among his associates and had the ability to accomplish much for the benefit of them and the public at large. Had he lived to an advanced age he would have remained one of the prominent figures in this state, for all that is best in the medical profession. He is survived by a wife, two sons and daughter. His mother died, at the age of 84, a few days after his death.

Public memorial services were held, under the auspices of the King County Medical Society, on the evening of July 22. Appropriate addresses were made by Hon. E. C. Hugres, Drs. J. H. Lyons, P. W. Willis, L. R. Dawson and C. A. Smith, of Seattle; J. R. Yocum, of Tacoma; K. A. J. McKenzie, of Portland.

The following resolutions were passed.

RESOLUTIONS.

Whereas, We honor ourselves in honoring the memory of a respected and worthy co-laborer; and

Whereas, We are now stricken with grief by the untimely demise of our fellow citizen and professional brother; and

Whereas, It is fitting and right that we attempt to express our sorrow and our respect for the character and attainments, both professional and civic, of our lamented friend; therefore be it

Resolved, by the King County Medical Society in special memorial session assembled, That we deplore the death of Dr. Frantz H. Coe as a calamity to the medical profession of Seattle and the State of Washington, and to the community which was the field of his labors as a physician and citizen.

Resolved, That in the death of Dr. Coe, the profession has lost one of its most brilliant and successful leaders; and the community one of its most earnest and valuable citizens. Be it further

Resolved, That the unlimited energy and enthusiasm and the exhaustive thoroughness displayed by Dr. Coe in his every day life as a physician and surgeon, and his unselfish devotion to the civic welfare may well be taken as a fittting example by all the younger men of the community. And the memory of his life and labors will be an inspiration to us all.

REPORTS OF SOCIETY MEETINGS.

TRANSACTIONS OF THE FIFTEENTH ANNUAL MEETING OF THE WASHINGTON STATE MEDICAL ASSOCIATION AT SEATTLE, WASH., JULY 12, 13, 14, 1904.

President, F. H. Coe, Seattle; Secretary, A. H. Coe, Spokane.

TUESDAY, JULY 12.—Morning Session.

The meeting was called to order by the president at 10:30 a. m. Minutes of the fourteenth annual session, held in Spokane, were read and approved.

An address of welcome was delivered by Hon. R. A. Ballinger, Mayor of Seattle, as follows:

"Mr. President, and members of the State Medical Association: It is a great pleasure for me to meet with you this morning, assembling in our city to carry on the work of your convention.

"I wish to say, in behalf of the citizens of the city of Seattle, that we rejoice to have you with us, and it will be the purpose of the resident members, as well as our citizens, to show you that the people of Seattle and this community are open-hearted, and that they desire to promote all things in the State of Washington which work for the best interest of the entire Commonwealth. The medical profession, like the legal, of which I am a member, has a great work to perform, not only in the communities to which the several members are apportioned, but throughout our entire country. The influence of the individual members of this profession upon the civic work is a matter of great importance. Whether it be for good or evil, for the elevation of morality and for higher tone of character, depends upon the individuals constituting your membership, as well as those composing the legal and other great professions. It is with great pleasure that I look over the physicians of our own city and state, and find among them men of elevated character, high tone of morality and pure ideas of the ethics of their profession; and yet I do not believe that the men of higher character are sufficiently diligent in keeping their professions clean and pure, and up to the higher standards. We are constantly disgraced in the public mind and our professions brought into contempt by men who have no right to exercise a license. In my own there are men who follow no other business than to rob the public and disgrace the profession, and I presume it is the same in yours. In assembling here, and in your individual efforts, I trust you will all work to a higher idea of development, and of the ethics of practice, as your work is for the benefit of humanity, for the healing of the sick and the care of those who are distressed in the community.

"Unfortunately in this community, under the charter by which we exercise authority, neither the people nor the legislature have seen fit to give the people the power to establish a workhouse. We are obliged, under the present conditions, to rely upon the law which gives to the county the authority to care for the poor. It is a strange condition of affairs that a great municipality like this has in no sense considered that important thing of caring for the poor and of the indigent sick, and of establishing those necessary things to look after the human side of life; but that is accounted for, I believe, by the fact that we are so rapidly progressing, stepping almost from a village to a city, and from a city to a metropolis. And yet it is the duty of the members of your profession as of the legal to look at these things and see that the law and government keeps pace with the progress of our commonwealth. If we do not do it, it will remain undone, because we are the advance agents of these things. I am heartily glad to meet you, and in behalf of our city, and in behalf of our people, I bid you welcome."

A letter was presented from the Seattle Athletic Club, extending the privileges of the club to visiting members.

Dr. Sharples, of Seattle, replied to the Mayor's address, emphasizing the necessity of legislation to provide for the indigent sick. He also referred to a needed reform in the local matters of public health, favoring the abolishment of the city Board of Health and the appointment of a health officer, with an efficient salary, who shall assume the whole responsibility of the department.

Secretary A. H. Coe reported as follows: The Judicial Council, at the last meeting, advocated a plan of the secretary writing to each of the county secretaries and through them endeavoring to collect some of the money of the members who were in arrears to the old society. I wrote a number of letters and have to report the munificent sum of seven dollars as the outcome of all that work. Three counties have not been heard from.

Treasurer J. B. Eagleson presented the following report:

Balance on hand from last year	$ 68.72	
Received from Secy., dues from last meeting	470.00	
Paid out voucher No. 26, Nov. 10th, expense last meeting, visitors from East, local expense		$353.00
Voucher No. 27, March 30th, preliminary printing for this meeting		6.50
Voucher No. 28, May 24th		4.75
	$538.72	$364.25
	364.25	
Balance on hand	$174.47	

The following committee was appointed by the president, to investigate the discrepancies in the accounts of Treasurer Eagleson and Secretary Coe: Mitchell, of Seattle; Semple, of Spokane; Johnston, of Colfax.

Dr. C. A. Smith presented the report of the committee of arrangements, calling attention to the program and describing the social events that had been arranged for the different days.

On motion of Dr. Willis it was voted to extend the privileges of the floor for discussion to all visiting physicians.

Report of a Case of Perforation of the Gallbladder in Typhoid Fever, with Remarks on the Diagnosis and Treatment. By P. W. Willis, of Seattle.

A child of 10 presented a typical course of typhoid fever. At the end of five weeks, when convalescence had begun, she suddenly developed severe pain in the right, upper quardant of the abdomen, followed by a rapid rise of temperature and pulse. Immediate operation disclosed perforation of the gallbladder near cystic duct. This was closed with silkworm gut after opening the fundus and stitching it to the peritoneum. She did well for two weeks when symptoms of obstruction appeared which operation showed to be caused by adhesion of the ileum to the wound. She died thirty-eight hours later from general peritonitis. Immediate operation is called for in these cases, after early diagnosis, whether the perforation be of intestine or galbladder. Pain, rigidity and tenderness are the most important symptoms.

R. C. Coffey, of Portland: This case is interesting to me because at present I happen to have two of the only three cases of gallgladder disease which I have ever seen pertain to typhoid fever. We frequently find gallgallbladder cases which have given a history of one, two or more attacks of typhoid. The question arises, is it a fact that we have had this typhoid producing the condition which caused the gallstone, or do we have cholecystitis producing symptoms similar to typhoid. I have one case under treatment at present, operated upon four weeks ago, which had given this history of two prior attacks of typhoid. The gallbladder was at time of operation gangreuous, with obstruction of cystic duct and pus in the gallbladder, apparently traceable to typhoid fever attacks. Another case had a temperature of 104°, gave history of chill and fever four weeks prior, with pains in the right hypochondriac region, almost a typical picture of gallbladder disease, and yet the patient had typical phases of typhoid. I was uncertain as to diagnosis, called in consultants, and they decided it was probably a gallbladder disease. Upon opening the abdomen wet found purple spots on the gallbladder, but on opening the gallbladder there was no stone. While the patient's temperature came down a few degrees it was not relieved, he continued a typical case of typhoid, developing a mastoid abscess. I believe in the majority of cases it is probably not advisable to attempt a very radical operation. In cases of typhoid, perforation most frequently takes place after patient is in a low state of vitality.

Woods Hutchinson, of Portland: I was about to ask whether a mere medical man might be allowed to enter such a discussion. I think we are getting to the point now where we can place the medical aspect of diseases of the gallbladder, even including gallstone. In other words, diseases of the gallbladder are emphatically the results of infection; it is simply a question of the degree of infection, and the presence of gallstones indicates infection at some previous period. You are familiar with the experimental evidence upon which this statement is based. All experiments, every possible method of inducing formation of gallstons, utterly failed until the presence of the colon bacillus or some other infective agent was introduced. So when we have a disturbance of the gallbladder, it is of some importance to find out what has been the nature of the infection. As soon as that has been discovered, in my judgment, the gallbladder ought to be removed. Dr. Willis' paper shows rather a common result of typhoid. Within the last eighteen months I have been in consultation in three cases of typhoid fever accompanied, and some times preceded, by stone. They ran typical cases and gave the Widal reaction later. The question was for a time whether we had to do with typhoid, secondary infection of gallbladder, or primary cholecystitis giving rise to these symptoms. The matter is one of indifference so far as the result is concerned. Whenever the gallbladder becomes the site of inflammation it should be removed whether the stones are present or not. The moment that it becomes the site of septic infection it is a source of danger.

Wilson Johnston, of Colfax: I have observed, contrary to Dr. Hutchinson, that my cases have followed typhoid, and some eight or ten days after fever had subsided and temperature normal, there would be an attack of jaundice and a run of fever for four or five days. The question with me has been whether many of our cases of relapse of typhoid have not been due to an infection of the gallbladder or some other structure of the body developing a fever and running temperature for four or five days or two weeks. One of these cases of some five years' standing had a violent attack of jaundice, a moderate amount of periodic pain, two or three times a day for four or five days. Temperature finally subsided. Patient refused operation and for five years now has been free from pain, so I can hardly agree with Dr. Hutchinson that one attack of jaundice following typhoid would be an excuse for extirpating the organ. If it were mine I would not want to take the chance.

P. W. Willis, in closing: As to cause of infection many of the gallbladders studied have shown pure cultures of typhoid. On the other hand, a large proportion of cases show the colon bacillus and other infective organisms. As to removal of gallbladder, I feel Dr. Hutchinson was right again. It has been said that infection of the gallbladder is a common cause of collapse. Who has not had a patient with an attack of appendicitis who has been free from pain for five years? But that is no reason why he should carry a stick of dynamite around with him. Because he has been free from pain does not indicate that he will always be so.

Headache, a Disease, by R. W. Perry, of Seattle.

The writer first described a common attack with the usual symptoms of sight, taste, touch, heaving, etc., with special reference to those of sight, including the phenomena of the spectra and transient forms of half vision. The disease is divided into the always manifest form which is prolonged throughout life and resists all treatment, and the latent which is made manifest by auxilliary causes as nerve exhaustion and anto-intoxication. By removing these causes this form is made amenable to treatment. Errors of refraction and lack of muscle balance are fruitful sources of nerve exhaustion, while uric acid or that form of intoxicant which predisposing individuals develop from a meat diet take first place among the auto-intoxicants.

A. G. Greenstreet, of Seattle: I object to the paper for the simple reason that it seems to me misleading. "Headache, a Disease", seems to me no argument at all. To call any sort of an ache or pain a hedache does not seem to me fair, and headache is such a common ailment, associated with nearly all diseases—all of the infectious, uterine, digestive, many diseases of the heart, brain, fever, syphilis of brain, and so on down the scale—everything causes headache at some stage or other. I see the doctor has kept away from all these and confined his remarks to migraine and its various symptoms. To call the headache of migraine a disease, is not very clear. There is little known of the pathology of migraine. It has been asserted recently, on good authority, that it is nothing more nor less than a complex of symptoms due to eye strain. Dr. Perry says very little about headaches due to this cause and to various defractive errors. Many headaches are associated with errors of the ocular muscles; also errors of refraction. I think in these cases the eyes should always be examined.

J. W. Bailey, of Seattle: I do not agree with Dr. Greenstreet as to eye strain. I have a patient under my care who, when one of these attacks commences, sees most beautiful mosaics, generally with one eye. Numbness comes on in some part of his body (tongue and fingers), headache on opposite side from ocular symptoms; vomiting follows which gives relief. This lasts until sundown, generally eight or twelve hours. He finds that tobacco smoke, bad air, crowds and late hours bring this on. He may be able to head it off by a dose of salts or calomel. He was referred to an oculist who found he was far sighted and had astigmatism, and some unbalancement of the muscles of the eye. This was corrected. In mild cases, when he felt the symptoms coming on, a long walk in the open air would sometimes prevent it. He usually takes physics, salts or calomel, and wears his glasses, and the effects are practically stopped.

Dr. Greenstreet added: May I be allowed to say that the doctor misunderstood me when he thought I said all these cases were due to eye strain. His argument is not very good. In hypermetropia or various affections of muscles, diagnosis cannot be made at once. It takes some time for the muscles to adjust themselves; also for the accommodation caused by strain to be relieved by the glasses. It takes the muscles some time to get back to balance; it frequently takes months. Sufficient time should be allowed before you can decide whether it is due to eye strain or not.

N. D. Pontius, of Seattle: In a true case of migraine you can expect less from refraction than from any other case, as a general rule. Some cases are cured; but true migraine I do not think can be cured by refraction. In astigmatism, hypermetropia, muscle unbalance, etc., I think one is very unwise if he gives a patient full assurance of being cured. It is becoming rather preposterous to attribute all symptoms to eye strain. A true case of migraine is just as often relieved by an emetic or physic as by correction of refractive error.

W. T. Williamson, of Portland: In a general way all these cerebral symptoms, whether of headache, vertigo or any of the manifold disturbances that occur may be augmented by ocular disturbances, and because this fact was for a long time overlooked it developed upon Dr. Stevens, of New York, some years ago, to make conspicious and emphasize the importance of this special feature. He assigned to it the almost exclusive agency in the production not only of migraine. but of chorea. polyopsia and many major nervous disorders. In this we are simply carrying out the law of advancement, by exaggerating in a marked degree, of some new features of knowledge, that it may arrest attention and receive subsequently the proper modicum of respect. This I believe an unwarranted exaggeration of eye disorders. I regard migraine more in the light of the position taken by Landon Carter Gray. He found that it was perhaps more the expression of some nervous constitutional disease of which polyopsia is perhaps an expression rather than of an especially localized morbid condition. I believe there is a necessary predisposing nervous weakness. excitability and the presence of eye strain or a thousand and one other disorders of function, especially those directly connected with the brain, which may suffice to produce an attack of migraine. That it is not dependent upon ocular disturbances is proved. first because not always present, and second when found present and corrected the disease is not remidied any more than in polyopsia, etc.; third because on removal of other disorders of nervous system, such as affections of ear. nose, or more remote parts, we have temporary, or in a degree. certain improvement. I believe that migraine is an expression of a general morbid, nervous disturbance of which there are many exciting causes, only one of which is ocular disturbance.

Dr. Perry, in closing: I have taken the title "Headache, a Disease" in contradistinction to Headache as a Symptom. Because we do not know the pathology is no reason we should not call it a disease. As to contraction of field division I think there are two visual centers, one in the occipital lobe and one in the angular convolution. Of the one in the occipital lobe, the right side has to do with the right half of the field of vision in each eye. A definite lesion there produces a definite lesion in either eye. The highest center is found in the angular convolution. This has to do with the whole eye or the general field of vision. A lesion in one of these centers will cause a blurring or a narrowing of the field of vision. In contraction of the field of vision there is a probable loss of sensation referable to the angular convolution, in which the peripheral fibres are attacked. In respect to ocular causes, no doubt plenty of people have errors of refraction with no other disturbance of any kind.

Squint and the Fusion Function. By David De Beck, of Seattle.

Donder's explanation as to the etiology of squint is that there is a definite relation between the function of convergence and the function of accommodation, and that in hypermetropia this is at once broken up. Either convergence would be maintained at the expense of clear vision; or clear vision would be obtained and then excessive convergence would throw one visual line across the other. Worth. of London, recently came to the conclusion that the fundamental factor was a lack of the central power of fusion. He found that certain visual functions are pretty well developed at birth and some are developed later. Only in the second and third year is developed the power of fusion. He places the lack of proper fusion power as the prime factor in the etiology of squint. In the treatment of squint he insists that if you can take a child at the time when the fusion sense is naturally developing, you can train this fusion sense in those children in which it is so weakly developed as not to maintain binocular vision. He has devised an instrument, the "amblyoscope", with a series of pictures requiring simultaneous perception or true binocular fusion. When these children are seen in the years in which fusion is naturally developing, three to five years, not later than five if possible, if you have developed the fusion sense by these methods, you have secured a radical cure. With such a development of the fusion sense a binocular vision will be maintained, and you have secured a vision of 20/20 in each eye. This you can obtain in almost all of these cases taken early enough, excepting only those rare cases of congenital amblyopia.

N. D. Pontius, of Seattle: The function of fusion is distinct, though modified by accommodation and convergence. Like other functions it is variable. Some patients have a high degree of hypermetropia, yet never have convergent squint for the simple reason that there desire for binocular vision is so great that their relations are so adjusted that they never squint. Where there is a high degree of hypermetropia and you have also exotropia, the eyes accommodate a great deal. In that case the fusion function is very poorly developed. A short time ago I saw a patient whose fusion function was so poorly developed that the patient could not overcome a 2° prism, yet he had no symptoms referable to eye strain. He had some astigmatism which was corrected, but even then the fusion impulse was no better. As a matter of training children it is not enough to get a child to see both pictures; the child must get fusion. He may see both together, but unless he has a picture which produces stereoscopic vision he has no clear fusion. The best rule to follow in a small child with convergent squint is to correct the error by a number of sittings and not depend on one retinascopic examination. Then have the patient use atropin for two or three months, keep him away from play things; get the accommodation thoroughly relaxed, and the child will learn to fuse. He must learn himself. At the end of two years, if the child still persists in squinting, then think about doing a tenotomy. Of late years there is a great tendency to abandon tenotomy for advancement of the muscles. If convergence is due to abnormal stimulation of convergence it is wrong to lay the blame on the external muscles. If you shorten the external muscles you produce an abnormality in muscles which before were normal. It is difficult to shorten the interni sufficiently to overcome external squint.

Dr. De Beck, in closing: I wished only in this paper to draw particular attention to the fact that we have in the cases of convergent squint in small children a time when, by proper training of the natural functions, there can be a restitution of conditions that will lead to permanent cure. After this time is over other things come up, as to relation between convergence and accommodation. I brought the question up simply to impress upon you that there are one, two or three years of the golden chance for giving the child a future with a perfect visual apparatus, and if you loose that chance the child is hampered for life. After that time fusion cannot be developed to any extent. Then tenotomy comes in. I do not think tenotomy is a scientific operation. It makes the strong muscle as weak as the other. I purposely avoided questions as to treatment of cases in later stages.

AFTERNOON SESSION—2 O'CLOCK.

Committee on Nominations of five members was elected as follows:

Chas. McCutcheon, of Pierce; James Chisholm, of Snohomish; W. A. Shannon, of King; J. M. Semple, of Spokane; Wilson Johnston, of Whitman.

The following resolution, signed by Drs. Eagleson and Sharples, was presented and unanimously adopted.

WHEREAS, It seems to us, the members of the Washington State Medical Association, that it is an incumbent duty on every community to take proper care of the indigent sick, and,

WHEREAS, It appears that, in many of the communities of this State there seems to be a clash between city and county authorities as to the proper divisions of responsibility under the present existing laws, and,

WHEREAS, It appears that there is no provision in the laws of the State of Washington for the care of the indigent sick by the city and county combined, now, therefore, be it

RESOLVED, That it is the sense of the members of this Association that the Legislature of this State should pass a law providing for the maintenance of a joint hospital for said indigent sick by the city and county, and provide for a proper distribution of the expense by such authorities in the maintenance of such a joint hospital, and, be it

RESOLVED, That the secretary be instructed to have this resolution printed and mailed to each member of the legislative body that will meet in Olympia the first of the coming year.

President's Annual Address. By F. H. Coe, of Seattle (See page——)

At the end of his address the President added:

"There is another matter I want to speak about—the education of the nurses. Reverting to our experiences as far back as 1889, remember how few we had at hand of the now abundantly trained nurses. You know how much is dependent upon the execution by her of your orders. There is a tendency as soon as a man establishes a small hospital of any kind to get a training school in connection with it. This seems to me rank selfishness, which scatters about training schools without adequate methods of instruction. Is it too much to appeal to the educational spirit of the profession that, if a training school for nurses is established, it should be thoroughly equipped with good lecturers, good instruction and good supervision. We realize today more than we ever have how much the result of our efforts is dependent upon the services "of the nurse".

H. M. Read, of Seattle: As to medical education in connection with the state university. I wish to emphasize more distinctly to members of the Association the urgency of keeping this matter before us. While this movement may apparently have been blocked for the time being, I wish to say from personal knowledge, as a member appointed to wait upon the President of the University, that they are far from abandoning the intention of organizing such a course. I was also impressed with the fact that not only was a pre-medical course to be conducted by non-medical men, but that they contemplate in the near future the establishment of a medical course in connection with the University. This pre-medical course is intended to obtain credit in any institution in the United States. I think we cannot take too firm a stand upon this subject and we will have to be on our guard. It is more than true if there is anything we do not want, it is more mdeical schools, especially of that standard.

I move that a committee be appointed, members of this society, who know well the regents and men in authority at Olympia, to make it their duty to see that it will not only be impossible at the present time, but in any future time, to establish such a school until such time may arise when there may be a large demand for such an institution, with sufficient funds to properly equip it; that it be their duty to suppress any movement at any time it may make its appearance.

J. R. Harvey, of Sunnyside: I wish to second the motion and for the reason, especially, that such a school is a waste of energy and of means. This is an age when capital is concentrating itself, when men of influence are uniting their forces and these smaller institutions of various kinds, commercial and educational will fail. I see no need of the State of Washington beginning a medical college that will become a failure. We had better give our efforts to the greater universities of our nation.

W.A . Shannon, of Seattle: I am glad this matter has been brought up. It is quite proper we should discuss it here. It will be a year before we meet again, and unless some steps are taken now the matter will certainly go through. An attempt has been made in the past to establish a medical department to the University and through the efforts of some medical men in this state the matter was finally dropped. It has been in abeyance since until recently when it is cropping up again. The tendency of medical education today is in centralization in the great medical centers of large cities, where there are properly equipped hospitals, plenty of clinical material, and everything for the proper teaching of medical subjects. It is aboslutely absurd at the present time to establish a medical department in connection with the University and unless we take some vigorous means at this meeting it will be established. I trust the matter will be thoroughly discussed and steps taken to inform the regents who know nothing of this. They naturally think our opposition is simply the result of our personal and financial interest in the matter and we want to explain to them that those are not our motives; that it is in the interest of the students that they should go to large medical centers.

J. W. Bean, of Tacoma: The question was discussed in the Pierce County Medical Society a few weeks ago, and we highly commend the action of the King County Society in bringing the matter up.

The motion was unanimously carried.

Chas. McCutcheon, of Tacoma: Dr. Coe has given a splendid address, and there are many things in it well worthy of consideration, but unless we consider them it will be the same as though he had read his address at the close of our session. I move that a committee be appointed to consider the President's address and segregate the various matters needing attention and report on the same to the association. The motion was seconded and unanimously carried.

The following committee was appointed to make a report as to recommendations on the President's address: H. M. Read, of Seattle; W. S. Durand, of Everett; Chas. McCutcheon, of Tacoma.

J. B. Eagleson said: Our Secretary has notified us that the committee to which was referred the work of the society have absented themselves, and I think we should appoint a committee to confer with members of the Association and recommend any changes they may think proper in the Constitution and By-Laws. I move that a committee of five be appointed by the President to go over the Constitution and By-Laws and report before the end of the session. Motion carried.

The following committee was appointed: J. B. Eagleson, C. A. Smith, E. E. Heg, of Seattle; H. P. Howard, of Everett; H. R. Wells, of Yakima.

The following committee was appointed to act temporarily with P. W. Willis on the judicial committee: G. S. Peterkin, J. R. Harvey, Chas. McCutcheon and H. W. Dewey.

What is Fever? By Woods Hutchinson, of Portland.

We know fever by its clinical phenomena but our descriptions of it simply confirm our ignorance as to its real nature. Is animal heat a vital necessity? Temperature is the result of the waste product of the bodily machine. The normal temperature of animals varies from 85° to 118° in different species. Plants have temperatures 3° to 10° below their surroundings. It is commonly believed, when fever sets in, that something has set a match to us. The higher the temperature, the greater the incapacity. There is utter stoppage of metabolism. The only thing that increases in fever is the output of urea. The change in fever is the change in anaerobic conditions of the tissues. The mechanism that paralyzes the bodily machine is one of the toxins of an infective disease or an anto-toxin. The toxin first acts by depressing the temperature and fever is a reaction on the part of the body to expel it. Hence the conception of cold as a source of disease. Fever is only a symptom. We should not employ anything depressing the vitality to relieve it. The fever itself is less dangerous. Of itself it is harmless. In many cases it is our best friend.

J. M. Semple, of Spokane: It seems to me that while it is true combustion largely causes fever, and that it is a symptom, I think the doctor overlooked to some extent the question of the central nervous system on the rise and fall of fever. I do not believe it is fair to compare the lower animals with the human. There must be something peculiar that will keep the temperature of an individual at the normal figure of 98.6°, notwithstanding the fact that the medium about us may be 32° below zero or above bodily heat. That something is located unquestionably in the brain. Some center governs this heat. There are times in health when combustion is materially increased without any material change in temperature. There are times when disease causes great exhaustion without any temperature. Consumption is often found with little rise in temperature, and yet constant wasting is going on. The same is true of many other diseases. There must be a center which regulates this heat—a center that increases and a center that lowers it—unquestionably three distinct centers. It is a well known fact in certain lesions of the brain, temperature rises suddenly and in others the temperature falls. Disease affects the brain centers unquestionably, and I feel there is where we must look largely for results when we arre treating disease. He mentioned antipyrin as a good thing in certain diseases. I have seen collapse caused almost to the point of death by one dose of antipyrin in typhoid a little larger than the dose mentioned, so that those things cannot be used harmlessly as he says. They do have a powerful effect in certain diseases.

H. M. Read, of Seattle: The doctor is wise in staying on the outside of the question. Until we know as much about animal or organic as about inorganic chemistry, I do not know as anybody will be able to tell the doctor just what the process is that develops fever. To make the broad statement that we do not have oxidation taking place in the body, that the amount of oxygen absorbed bears no relation to the amount of tissues consumed, is saying a great deal. I would like to have the doctor demonstrate why this is so. If he knows, then he knows more of organic chemistry than most of us. We know people have fever, that it tears the blood to pieces; we know that from the condition of the blood as examined under the microscope, by the waste of tissue, by the increase of oxidation products. probably due to a tearrng down process instead of a building up process which takes place in health. How that occurs any one can tell him. We would like to have him tell us his reason for the view he takes. It is an easy matter to ask what fever is. Very few know. It is an expression of a pathologic process. Men who are making a study of cell activities, processes that go on in the cell under certain pathologic conditions, know that these cells and substances, largely albuminoids of complex arrangement, are destroyed, but they have not the slightest idea of the process; they know nothing of the number of molecules that go to make up the various albuminous substances. We can say fever is fever, but we know that heat is developed largely by a process of chemical activity. In all probability the process is the same in organic or animal.

P. W. Willis, of Seattle: I wish to thank Dr. Hutchinson for the point about people taking cold. One of the trials of my life is to get people to believe that they do not take cold, but that it is infection. It is proverbial when you are questioning a patient that has septic trouble, that the nurse allowed him to become exposed and he took cold. There are a few points in the doctor's paper with which I do not agree. He says we take the temperature after the chill is over. I believe I have had temperature taken during chill and found it high. I know from my own experience; I have felt chilly for a whole day and during all that time have had actual elevation of temperature. As to treatment of typhoid, there is an immense amount we do not know. Any one who has seen a patient treated by the old method of allowing the temperature to rise and see the patient's mind clear and abdomen come down, knows there is something besides removing the actual fever. Whether it is simply removing the fever or removing entirely the cause, I do not know. Another point is the action of these drugs on the heat centers. I do not know whether there is anything recent in that line or not. He speaks of the germicide effect, but what is there in their action on heat centers?

Chas. McCutcheon, of Tacoma: I had a case last January of typhoid fever of the worst kind. Patient had three very severe hemorrhages about three weeks apart, all vital forces at the lowest ebb. After the fever had subsided I could not get patient to take nourishment. The temperature was normal for several days. Then another hemorrhage, and the temperature dropped to 95°, pulse dropping from 120 to 80. The temperature stayed down all day. Next day it went up to 105.4°, pulse to 140, then to 150. This was repeated three times. Next day it dropped down to 94, next day up again. On the sixth day I gave her quinine, 10-15 gr. and from that on, for two weeks or more, temperature stayed normal.

Kenelm Winslow, of Seattle: I would like to ask Dr. Hutchinson in regard to the nervous element. It does not seem to me he takes enough account of that. How can you have fever in patients where a clean sound has been used? In regard to treatment, how does he account for the beneficial effect of the Brandt treatment, with such immense improvement in all the nervous symptoms and general condition of patient. Horatio Wood, in speaking of fever, said "Whatever fever is, it is essentially a nervous disease."

E. E. Heg, of Seattle: I agree with Dr. Hutchinson. I think the essential point, as he says, is that fever is something to be noted and not combatted. I won't say I agree absolutely. The fever can be apparently reduced in disease by anti-pyretics or baths or anything else, and it comes back promptly until the underlying processes have disappeared. Coincident with the beginning of the Brandt method, they dropped the use of anti-pyretics such as coal tar products, quinine and other depressants, and I think the decreased mortality is due probably to that. Personally, in typhoid, I do not pay any attention whatsoever to temperature except occasionally.

Woods Hutchinson, in closing: The discussion has shown the thing that I was sure of. It is impossible to cover the ground in the limited time. You know what you have suffered from in my remarks, but you do not know what you have escaped. In regard to Dr. Semple's question, that I had disregarded the claim of the nervous system, I deny the claim of the nervous system to be regulator of anything; it is nothing but a middle-man. It is merely there for the purpose of taking orders from one set of tissues and transmitting them to others. It cannot help itself. It only obeys the strongest stimulus. The idea that the nervous system is ruler should have been discarded long ago. It is secondard only. When the nervous system produces fever it either opens the sluices of heat, letting the heat pass through, or else it acts as an acute irritant to the tissues just as toxin does. While the nervous system unquestionably plays a part you have got to bring the thing back to the problem of cellular chemistry. It is the changes that take place within the cell walls that are the important things in fever. As to the objection of comparing man with the lower animals, it is a bit hard on the animal. I am at a loss to say how we are to get information by any other means. If we limit to one species we are blocked off from very much information.

As to small doses of coal tar derivatives, I was talking about the intelligent use of such. I do not think the use of them is justifiable except in those places where we know the attack will be short. As far as I am concerned I think they do nearly as much harm as good. The fact that all processes in the body are those of ordinary chemical combustion is well known. The only question is as to where that process of combustion takes place—in the blood or in the cells. If it be in the blood, then the output of CO_2 would be increased in fever. Experiments of not one, but a dozen men have all shown conclusively that the output of CO_2 per pound weight is diminished in fever. Oxidation does not take place in the blood. From their point of view decomposition takes place in the tissues. Breaking down of the molecules of a high potential into smaller forms is enormously increased in fever as shown by the output of urea rising from 10 to 50 per cent. Decomposition in the tissue is the point of proof upon which I rest my statements.

In regard to the action of cold baths in typhoid, it is an improvement over any method that we have had before. I merely called attention to the fact that it was in acknowledgment of our lack of definite knowledge on the subject. If we were still obliged to treat syphilis and malaria in that manner, we would stand little chance. The benefit of the Brandt method does not consist simply in the reduction of temperature. The statement is made that the advantage of the cold bath can be got without any reduction of temperature, that it has some influence which we do not understand in maintaining the general nutrition of the organs, and quieting excessive metabolism. The Brandt system of treating typhoid is the best yet, but I think that, in some discoveries of Vaughn, we are at the starting point of something which will prove a definite germicide for the typhoid and not injurious to the tissues. When that day comes so much the better. Until it comes let us use the means that Heaven has given us, and avoid giving drugs as much as possible. I think we have benefited nearly as much by cutting out the drugs as by the addition of cold water. The problem is coming to gradually center itself around the fact that it is the changes which take place in the cell itself which control the temperature of the body. I do not see that we should be concerned about the factors which keep the temperature normal any more than why one man's eyes are blue and one brown. The fixed temperature is a sort of equation, as it were, between the activities of the organism and th amount of waste. Mere disturbance of temperature is not necessarily injurious although usually a sign of infection and intoxication.

Some Practical Points in General Paresis. By W. T. Williamson, of Portland.

The disease was first systematically described by the French about sixty years ago. Early diagnosis is most important. The prodromal period may extend from three to fifteen years. The first symptom may be the exaggeration of pre-existing mental characteristics. Then come abnormal mental, moral and physical conditions, whose value depend upon their comparison with the former normal state. Oculo-pupillary changes are important if present. Embarrassment of speech is the great pathognomonic symptom. The letter "r" and the linguals are especially troublesome. The paralytic type is more common in females, being a sing-song syllabing of words; the ataxic speech is confused and blundering, more common in men. The tremor is of value, being an early symptom, most marked in the tongue and extremities. The knee-jerk has been exaggerated as to its value, in the opinion of the writer being of no value. The combination of this with tabes is purely a coincidence. The presence of delusions and sense of wellbeing are not a universal symptom. There may be melancholy. The delusions of the paranoiac are sustained by logical theories while those of the paretic are permeated by dementia. Syphilis is considered the cause of a large proportion of cases. Also nerve exhaustion and other vicious conditions.

W. T. Miles, of Seattle: One point is vastly more important than any other, that is the early diagnosis of general paresis. A great deal of trouble can be prevented if people learn what is truly the cause of these troubles. I had a case about a year ago, which started with neuritis of the facial nerve. He went to a dentist and had nearly all of his teeth extracted from the upper jaw; said he could even notice a stench from the degenerated nerve. Nothing could be found, however. After that other symptoms appeared. Protrusion of the tongue was jerky; language was explosive and rapid, and the labials and linguals were twisted somewhat. Sent patient to hospital and had him out in a short time. Two or three months afterward he went back and then came on the dementia symptoms, muttering delirium, mania, loss of all control of the sphincters, and death inside of a week. I think early diagnosis is very important.

H. L. Ewing, of Norristown, Pa., Asylum for the Insane: I cannot add anything to what the doctor has said, except that he does not touch upon pathologic anatomy. The cells of the cortex are broken down and distributed. He also speaks of the diffuse straining of the cells, but there is not much change in the peripheral neurones, the changes being exclusively found in the cortex. The difference between the delusions in general paresis and in paranoia are that in the latter they are systematized, while in general paresis they are changeable, never the same from day to or almost from minute to minute.

H. W. Coe, of Portland: The question of differential diagnosis between paresis and other mental conditions is a very broad one and might be discussed indefinitely. I think the point that Dr. Williamson made, the change in character which is possible in paranoia by a little effort on the part of the examining physician, is quite an item of value in differentiating from this condition, which in many cases is very similar. I remember what Dr. Clewston, in Edinburgh, said to me a few years ago, following inquiry as to the character of paresis in this country, that he believed the character of paresis was changing, formerly the life of a paretic was about three years: now, he says, the average is about seven years, and it brings up the question whether or not, in the evolution of modern life, paresis has not come into existence. I remember in Ireland, at Killarney Insane Asylum, in something over five hundred patients, there was but one paretic, and yet, across the water, in the asylum at Wales, there were a dozen or twenty cases among the Irish of paresis, people having left their own country.

J. M. Semple, of Spokane: I admire Dr. Williamson's paper very much. I find some difference in my experience. One point is the question of etiology. He spoke of syphilis as if it were the cause of practically all. I believe that general paresis is a disease largely due to the conditions of modern life and that it is on the increase in all civilized countries. I believe it is due more often to worry and to alcoholic and sexual excesses than to syphilis; at least that has been my observation. As to the matter of having so few in Ireland, it is true that the Irish have less, not only of paretics, but of all classes of insane, than they do in the country or in England, but it is not true of the Irish in this country or in England. Before the Civil War the negroes were very little affected with insanity. Since then, when the burdens of life fell upon them instead of upon their masters, insanity has been increasing. The doctor spoke of the disease taking years to develop. I believe in a certain class of cases it is short and will follow an attack of mania. A prominent business man from New York was here and taken with mania which lasted several months; he apparently recovered, traveled in Europe for a while, came back, became paretic and died. The usual impression formerly was that it terminated within three years. I have notes of an unfortunate case of a relative of mine who died within three months of the time when the symptoms were first noted. I believe if you can remove organic disease of the brain, if you have contracted pupil, and especially unequally contracted, even before general symptoms are noticeable, the case should be looked upon as suspicious; it is very strong presumptive evidence of paresis.

Dr. Ewing said: In examining insane people, in perhaps one-fourth of the cases, we find unequal pupils, and yet few of these are general paresis. The length of life of paresis cases is increasing; perhaps it may be due to the better care given them. The treatment is very different now from what it was ten or twenty years ago. Even in the last five years there has been great change.

W. W. Potter, of Spokane: The doctor speaks of alcohol and tobacco in relation to this disease. I wish to ask in regard to other stronger narcotics, as etiologic factors in this disease, namely opium, chlorine, etc.

Wm. House, of Portland: This paper is one of peculiar interest to me, because the writer has succeeded in compressing within small limits a subject of vast importance. He has treated those elements of the subject which appear, or should appear to the general practitioner, these patients have been in the hospital several months it does not take an expert to diagnose them. Some say they can recognize them at a glance as they walk across a space of ten or twelve feet. In early stages, however, this is not so; indeed it taxes the ingenuity of the most expert and careful observer to make a diagnosis at the most important stage, before the period of delusion. For example, a case of a judge of the Supreme Court of the state of New York who, during the developmental stage, left his home and before he could be restrained, purchased twelve carriages. That man was posing before the public, trying most important cases and passing decisions in which were involved not only the character, but the life of citizens of that state. The early symptoms of paresis are not clear. There are, however, certain symptoms which may be used as almost pathognomonic and of a most definite and distinct nature; tremor, difficulty of pupillary reaction, and above all loss of facial expresssion. I do not care how early in the disease one sees a patient, there is almost always loss of facial expression; but it must be confined to either one side or the other. A test frequently used is some sentence such as 'Third cavalry brigade,' or 'Around the rugged rock the ragged rascal ran.' It is found that practically all paretics stumble even in the early stages. In New York City, in which the population is dense, 15 per cent. of the total admissions to asylums are paretics. In Ireland between two and three per cent. In cities of about one-half or one-third the size of New York they run about 6 or 7 per cent., which may be taken as a total percentage all over the United States. The utmost importance must be attached to differential diagnosis between syphilis of the brain and paresis. A patient with syphilis of the brain may recover under properly directed constitutional treatment. One of the tests is the reaction to large doses of iodine, which should be tried in suspicious cases regardless of history.

Dr. Williamson, in closing: I am pleased to note the interest taken in this subject. We would expect in a disease characterized by such uniformity of symptoms that at least some degree of similarity would exist in regard to pathologic symptoms, but such is not the case. The disease when first described developed much discussion, consequently every opportunity was embraced to make post mortem examinations and the results published, and it was at one time determined that it was encephalic meningitis; it was regarded as essential that there should be adhesions existing between the brain and the meninges. It has been found, as suggested by Dr. Ewing, that the cells of the cortex are generally involved, and shrewd observers working together for some years, with great opportunity of investigation, found that not only in the most superficial layers were the cells affected, but in several layers. This has not been generally confirmed, although occasionally found. Pathologically, as compared with syphilis, the difference lies in the fact that the cortex and superficial portion of the brain is commonly affected in general paresis, while in syphilis it is commonly found in the base. The disease causes most pronounced atrophy of the anterior lobes of the cerebellum, the base of the brain from the parietal regions backward not being so markedly involved. Dr. Coe refers to a change in the character of the disease. This is a point of great interest. Originally it was initiated by a marked or pronounced dementia, a convulsion or something simulating these. It was of short duration. Latterly the disease is changing until today there is an increase in the number of cases in which dementia, without the complications of even delusions and aberrations of a physical character without the presence of marked trophic lesions and changes and without the convulsions, and without the involvement of blood vessels is found. So the disease is passing into a gradual and less marked stage and its duration is longer. As to the small percentage in Ireland, I think perhaps Dr. Semple did not go far enough. There is not only less insanity found in Ireland as compared with some of the other countries, but as compared with the other insane there are less paretics than in any part of the civilized world. In France, where alcoholic and other excesses are greated, the percentage of paretics is greater than anywhere else in the world. In Ireland there is only 2 per cent., in France, in Paris particularly, where investigation was made with regard to the soldiery, it was found that among the soldiers about 10 per cent. of the insane are paretics; and among the officers, of all the insane of whatsoever type, 30 per cent. was found to be paretics. This would point to the theory that syphilis is not the only cause. Mental excesses of any kind will contribute largely to the disease. Dr. Semple also referred to duration. There are plenty of cases on record where general paresis was developed and the patient died within a week. Lesions were of a more marked type and involved greater physical shock. In diagnosis reference was made to the fact that the inequality of the pupil was of great consequence. Personally, I do not attach as much importance to this, especially to myosis, nor to the fact that one pupil is myotic and the other normal, as I do to the fact that one pupil may be normal and the other dilated. This I think of much less consequence than immobility. Where exposure of the pupils to light gives persistent refusal to yield to ordinary change I believe we have the most responsible method of determining a reasonable ground for expectation of general paresis. Delusions of persecution are the key note of paranoia; delusions of grandeur may or may not be present. If delusions of persecution blend with delusions of grandeur, it makes an excellent guide to paranoia. As to whether opium, chlorine, etc., are productive of general paresis, I believe not. It seems that while they are wasted and exhausted, and tend to anemic conditions and weakness, particularly of moral functions of mind, there is not so much general paresis as from an indulgence in alcohol, tobacco, etc.

Tuberculosis. By Ivar Janson, of Seattle.

The writer first dwelt on the universality of tuberculosis and queried, how is it that we do not all contract the disease? It is the result of inherited immunity through many generations. The survival of the fittest has preserved a race less susceptible. Nevertheless the public should be protected from the dangers of this infectious disease. This should be accomplished by the construction and maintenance of institutions by the State. The writer has seen recovery from the disease in numerous cases. He believes one can recover from tubrculosis and later develop it again. He does not believe in latent infection. For treatment, forced feeding, out-of-door life. Creosote is the most valuable drug, often a specific, in large doses even up to a dram three times daily.

The Etiology of Tuberculosis and its Governing Factors in Treatment. By J. J. Leiser, of Seattle.

Consumptives are benefitted by high altitude and dry air. This is due to extra lung expansion made necessary by rare atmosphere. Autopsies show tubercular lungs deficient in interlobular tissue. Hence the arteries are diminutive and the blood supply diminished. In disease they are so weakened as to become a fertile soil for tubercle bacilli. Cure results from over-development of normal parts of the lungs. This is necessary in order to take in a sufficiency of oxygen.

By extra lung expansion and growth a consumptive should cure himself unless too greatly debilitated. The writer believes climate and elevation an important factor in producing this condition. It is not important to attempt to destroy the bacillus but to strengthen the lung by access of an increased amount of blood. Elevation accomplishes this by compelling forced breathing. Cure is assisted by anything that inspires faith and confidence in the patient. The objective is to arrest the disease as early as possible. One lung destroyed, with the other in good working order, is preferable to two partly diseased. Too much cannot be said in favor of fresh air. Isolation and special consumptive hospitals are to be condemned. The writer deprecates the role assigned to the tubercle bacillus in the etiology of the disease. He thinks it overstated and that they are less a factor than anatomically weak lungs.

The Role Played by the Nose and Throat in the Etiology Tuberculosis.

By Hamilton Stillson, of Seattle.

The subject is divided into (1) Mechanical, (2) Bacteriologic considerations. Mechanical obstruction in the nose causes mouth breathing which results in the increase of residual air in the lungs and induces emphysema. The latter is one of the earliest signs of the pretubercular stage. The poor aeration leads to anemia and a resulting lowered resistance, leading to the invasion of germs. Hypertrophies and hyperplasias of the nose interfere with the moisture that is normally given to the inspired air. This leads to dryness of the air cells and a predisposition to tuberculosis. Nasal obstruction permits cold air to enter the pharynx. Hyperemia follows that is condusive to tuberculosis. Sifting the inspired air through the cilia is prevented; passive congestion is caused in the cerebrum. Hyperplasias also block the lymph channels causing lymph stasis of the brain which is conducive to tubercular infection. In respiration there is back-suction in the lymph currents in the neck. Interference in respiration increases this and leads to the deposit of bacilli in the apices of the lungs. The nasal passages and mouth are suitable fields for local tubercular infection. Systemic infection occurs by invasion of the vascular and lymphatic system in the nose and mouth. Bacilli can enter the circulation through the unbroken mucous membranes. In the mouth may be abraded tongue or gums. Ozena furnishes an ideal soil for the bacilli in the nose and often precedes pulmonary tuberculosis. The pharyngeal tonsil is a favorite site for an initial tubercular infection and is often associated with the pulmonary lesion. The faucial tonsil also can present the beginning of systemic tubercular disease.

J. B. Morris, of Lewiston, Idaho: I could not otherwise than compliment each and all of the papers. As to one dram of creosote at a dose, I do not think I have ever found a patient that would stand that much. It is almost equal to a cupful of cod liver oil two or three times a day. I think butter or cream would do just as much good and certainly be more palatable.

W. A. Shannon, of Seattle: I did not hear all of Dr. Leiser's paper. What I did hear, to a certain extent, I agree with. My experience is that no medical treatment is of avail in tuberculosis. I have advised creosote and all the other remedies and nausea resulted to the patient. I think, as the doctor suggested. we attach too much importance to the discovery of the tubercle bacillus. I think clinical symptoms are of much more importance in many cases than the microscopic examination of sputum for the discovery of the tubercle bacillus. In many cases we have symptoms long before we can discover any bacilli. Clinical symptoms and microscopic examination should be combined.

As to treatment, I think the main thing is nourishment, fresh air and rest. Patients with acute tuberculosis and a temperature should be confined to bed with absolute rest. As to diet I think they should be nourished as thoroughly as possible. I do not think it is always wise to send a patient away from all his friends. Sometimes it has a very bad effect. He becomes despondent whereas he should be kept happy. A pound of fresh butter and a pint of cream will do more good than all the cod liver oil you can get.

Dr. Harding: The wrater said he gave a dram of creosote per dose. He has gone farther than I have. By the carelessness of a patient I once gave forty drops three times a day. The patient had hemorrhage after hemorrhage. This was ten years ago and she is alive today; Whether or not the creosote had anything to do with it I am unable to say. It was the only medical treatment she had.

Orange Edwards, of Seattle: I agree with Dr. Shannon on treatment. I do not believe in sending the patient away. I would insist that we keep more of our patients at home and allow them to keep out of doors all the year round. The late Dr. Whitaker, of Cincinnati, had results in the treatment of tuberculosis which I think were due more to having the patient sleep out of doors than to the injection of tuberculin.

E. Janson, of Seattle: As to creosote, I have used more than dram doses with good results. I never give an adult less than ten drops, increasing up to 40, 50 and 60 drops, without bad results. The success with creosote is to give large doses if you expect any result. Ten drops is of absolutely no value. I read an account of Dr. Morris, from a certain saintarium in the East. He recommends the use of creosote up to 100 drops, to be continued for six months. I always give it in capsules on a full stomach and follow a glass of milk, and have never seen any bad results.

H. R. Wells, of North Yakima: I have always regarded climatic conditions and plenty of fresh air with proper surroundings as the best treatment for tuberculosis. I have never used creosote in large doses. Have had some experience in North Yakima and think patients improve more in a sunny climate without any medical treatment than they would in this climate even with the best of care and treatment. I would like to know if anyone can give information as to the treatment of tuberculosis of the glands of the neck as well as the lung, by the X-ray.

Woods Hutchinson, of Portland: There is abundant ground for difference of opinion upon this subject. I think it ought to be made a penitentiary offense to give drugs in tuberculosis. They distract the attention of the patient, do no good, rob him of one means of cure, that is, life in the open air with plenty of good food. Those who have studied tuberculosis know that everything has been of no avail unless combined with the open air treatment. I believe when you put a tuberculosis patient upon drugs you rob him of his one means of cure—the method of nature. Another statement upon which I would take issue is that tuberculosis is not necessarily a disease of the lungs. A tubercular patient has a larger lung and a larger chest in proportion to his body than you or I have. If you would forget his lung and treat him upon general principles we would do better. The cabinet was a ghastly failure—an invention of the evil one. All other methods of treating the lung have failed. Now we are strapping it down, and we have invented an elaborate strapping apparatus, by which you take a cinch upon the opposite shoulder and strap the lung down and allow the diseased tissue to cure itself. In my judgment it would be better to do nothing. Climate is better than anything else. If you get plenty of air it does not matter much what its quality is, temperature, moisture, or anything else. Put patients in the open air, even in our thirteen months of rain in Oregon. The sanitoria showing the highest percentage of results are those in the Black mountains, in Germany, the worst climate in the world, colder and wetter than any place else; and yet those people, simply by putting the patients in the open air, keeping them at rest, crowding them every day with a certain amount of food, have succeeded in getting 80 per cent. of cures, and these in many cases have gone the rounds of all the climates. Not only were meals prescribed six times a day, but the amount and just what was to be eaten, and the patient had to eat it. Dinner began at 10 o'clock. One patient at my table found it difficult to eat his prescription. When I went in for supper at 5, he was still there eating his dinner. He had vomited twice in the process. Consumption is a better name than tuberculosis. We would treat the disease a great deal better if we would forget there was such a thing as a bacillus. It is valuable for diagnosis, but when you have said that you have said all there is to be said about it. Cod liver oil, creosote, iodoform, are relics of the ages when remedies were administered and valued in proportion to their repulsiveness.

Thos. Parker, of Toledo. Ohio: While I heartily agree with this idea of internal remedies, I have never seen medicinal treatment do any good yet.

President F. H. Coe: When Dr. Hutchinson states that it makes no difference what the climate is or where it is, provided you have plenty of it, and lots of food with it, he may be all right, but the fact is, we are not going to send out patients out into the cold, damp and fog. It is practically impossible to force a tubercular patient to stay out of doors the year round. We have got to put them where they will work, sleep and eat out of doors. We cannot do it here. I want to ask Dr. Wells if he finds that the people who go over to Yakima do well there out of doors. I am anxious to find some nearby district where we can send such patients and have assurance that they will stay out of doors if we send them.

Dr. Richardson, of Colfax: Last winter I sent my patients to the Snake River country, below Lewiston, where they can buy land cheap, put up a little house and live out of doors. The temperature was never below 50°. I find our climate east of the mountains is all right in the summer. Consumptive patients are naturally despondent. You cannot get them to do anything unless you can raise their spirits. I find a hypodermic of strychnin, one-twentieth of a grain two or three times a day, livens them up and they are willing to do something for themselves. A patient will not get the same benefit in a climate that is depressing that he will where everything is favorable.. I believe the question of climate is one as to negative temperature. Where we have a change between day and night of from 40° to 50° it is not favorable for tuberculosis. As to treatment, I have derived benefits from the injection of serum of various kinds. I believe it is a powerful stimulant, and that it increases the resisting power of the leucocytes of the body and in that way raises the resisting power of the patient. I do not believe we will ever find a specific for tuberculosis, but the whole question hinges upon the prevention of it. It is all right to examine sputum, but when you do find bacilli present the patient is far along on the road, and the only hope is to diagnose this disease upon suspicion. Do not wait for physical or clinical signs. If a patient comes who is running a temperature, I believe in treating him for tuberculosis. I was pleased to hear Dr. Stilson's paper. I think the nose and throat, in many cases, is the point where infection takes place.

H. R. Wells: I do not wish to be understood as speaking for the Yakima climate, which I do not think is very beneficial. I believe the climate of the Columbia River county is more favorable than any in the State of Washington. I have always believed that if I had tuberculosis myself I should go to Colorado or Mexico, but I think the Columbia River is the best place in the Northwest.

Woods Hutchinson: One of the singular features of the disease that has troubled me for many years is how can you crowd into that poor consumptive more food than you could eat yourself, and yet he be none the worse but better for it. You cannot take a healthy man and put ten pounds on him in two weeks, but you can with the average consumptive. You can do it by simply giving him water. So far as the six German meals are concerned, they do not add up to very much. The Americans eat better food and get better results from it than any other people. One of my patients is consuming, and has been for six weeks, one and a half dozen raw eggs a day in addition to three square meals. He weighed originally 106 pounds. He is now up to 118 and gaining. Tubercular patients can stand this treatment. As to climate, the reason why our climate here is not adapted to tuberculosis is that, unless you have the discipline of a sanitarium or an unusually hard-hearted doctor, you cannot drive your patient out into the open air at all times. That is the reason I want to see a sanitarium established. We can establish a chain of these sanitaria and when we find patients not doing well in one we can move them to another. We have one of the best climates in this northwest country of any place in the world, and it is time we recognized it. Take our climate, make the best of it, keep our patients out doors, and we will cure 60 per cent.

Intestinal Intussusception. By W. S. Durand, of Everett.

After defining the term he mentioned four varieties: (1) Enteric, (2) Colic, (3) Ileocecal, (4) Ileocolic. It may also be single, double, triple, etc. The most frequent cause is irregular peristalsis, often combined with a circular contraction of the intestine or a lateral dimple in the bowel. Forty per cent occur in children, frequently due to improper feeding. Earliest symptoms are severe pain, bloody stools and mucus. Tumor is an important symptom. The doctor found hiccough very annoying. Diagnosis is usually very difficult. Different authorities were quoted on this subject. The only rational treatment is operative. He reported a case of a man of 39, who complained of general debility, constipation and abdominal pain. At first he was thought to be neurasthenic. Later he found a tumor in the left hypochondriac region which was diagnosed floating kidney and operation advised. But hiccough developed that persisted for twelve days. During the following four months were periods of vomiting, constipation, diarrhea, bloody stools, all supposed to be due to neurasthenia. Autopsy revealed the tumor to be an intussusception of cecum and ileum into the colon.

E. Janson, of Seattle, described a specimen from an operative case of intussusception of Meckel's diverticulum. The man lived five months after the intussusception. The lumen of the intestine was so small that a closed forceps could just be inserted.

Adjournment till 9:30 a. m.

WEDNESDAY, JULY 13.

MORNING SESSION—9:30 O'CLOCK.

Heart Failure Due to Indigestion. By L. R. Markley, of Bellingham.

The writer described the case of a man of 60 whose heart and lungs were sound. For supper he ate pickled smelt, followed by severe abdominal pain, for which he was given a hypodermic of morphin and atropin. In ten minutes he complained of numbness of extremeties, had a convulsive tremor and was dead. Another case, a man of 65, a dyspeptic, had a similar attack but recovered. Later he dies in another. He described other cases of dyspeptics who experienced sudden attacks of heart failure, relieved by hypodermics of nitroglycerin, digitalin and strychnin. He thinks the cause is the generation of ptomains or leucomains, which are powerful poisons and their absorption.

J. P. Sweeney, of Seattle: Heart failure due to indigestion, depends on whether the nervous system is in full tone or in a state of exhaustion. In all cases you will find some difficulty of the ganglia of the heart, some fatty degeneration, some inhibiting mental condition affecting the ganglia of the heart directly through the pneumogastric nerve. The doctor's cases are really such, in my mind, because the treatment outlined is entirely stimulating and proper after the cause is removed. Those using alcohol to excess, with weakened digestion, permit themselves to eat heartily causing dilation and pressure on the inhibiting action of the ganglia of the heart which keep it working automatically. The individual of the neurotic temperament is more susceptible to that type of heart failure due to indigestion. We often see this in a lady who has been to a reception or party and become over excited, and then eaten heartily, as type of heart failure due to indigestion. In these we find suffocation, deep breathing, flatulency and depression. Relief is brought about by quieting the nervous system until the stomach can be washed out. Then the heart will regain its normal movement.

Wm. House, of Portland: It seems to me that the doctor's cases were ably reported and deserve considerable attention. I am opposed to the term "heart failure", because it expresses a condition which exists in every individual immediately before death. However, it is established that, in certain cases of indigestion, there is a distinct tendency to a syncope comonly attributed to heart failure. I do not differ from the writer of the paper in that it may be due to the development of a toxin in the intestinal tract, but I think the direct cause of the disturbance, in ninety-nine cases out of a hundred, is the development of gaseous substances within the wall of the stomach. In working among nervous patients it is not at all uncommon to be called to one in the middle of the night because his heart is beating rapidly. Upon examination almost invariably the stomach was found distended with gas. Notwithstanding the doctor's expressed desire for the use of heart stimulants, I have given relief in every one of those cases by the administration of ordinary bicarbonate of soda, spirits of amonia, a few drops of whiskey, or a mustard plaster over the stomach, followed by a saline. I am certain that many of these attacks of extreme rapidity are due to a mechanical cause, excessive secretion of H Cl, which acts upon some mineral substance producing gas, not necessarily a gas of fermentation. The stomach is distended and pushes the apex of the heart upward and to the left, and suddenly with a violent nervous start the patient awakens, instantly the pulse is extremely weak, the face becomes pale. He relieves himself by belching gas, or, by the administration of some simple remedy, the heart goes back to its place, and drops down to 70 or 80.

H. L. Lazelle, of Seattle: I think certain cases of sudden heart failure and sudden death, that are attributed to indigestion are not so at all, but due to some lesion that is overlooked. There is a condition which has of late been spoken of to some extent, known as status lymphaticus, where there is enlargement of more or less of all of the lymph tissue, and frequently enlargement of the thymus gland. Persons who have this peculiar anatomic structure have been known to die very suddenly from apparently very trivial causes, such as hypodermic injection of antitoxin. Also they may die suddenly from anesthesia.

H. M. Read, of Seattle: The objection to the expression of "heart failure" is well brought up. It is a blanket thrown over cases from infancy to old age. We should bear in mind the condition of arterial sclerosis. These cases are affected by any digestive disturbance. Anything that will rapidly lower or raise blood pressure—more particularly lower it—will disturb them quickly. An apparently trivial derangement of the pulsating motion of the heart, due to disturbance of its muscular tissue, may run over a course of a great many years; the exciting cause may be some acute infective disease of which typhoid fever is one of the most common also pneumonia, scarlet fever and rheumatism. Those cases coming on at night in neurasthenic individuals from accumulation of gas rarely result in more than functional disturbances, but those are the very cases in which we may overlook the condition mentioned. I should be suspicious of a heart that would be disturbed three or four times a month over a period of six months or a year. I should be careful about attributing it to indigestion. There are too many factors in the functional disturbance of various organs that have a direct effect upon the heart to lightly disregard these cases or to be careless in grouping them. In advanced age patients suffering from any kind of heart affection are likely to have heart degeneration, arterial sclerosis, or disease of the vascular system.

W. C. Hastings, of Seattle: It is well to be armed and ready to do something. The only remedy I have used is amyl nitrite in these night attacks, and aromatic spirits of amonia, as suggested by Dr. House in indigestion and overfull stomach.

Dr. Markley, in closing: I think there is a difference between poisoning due to ptomains and that due to gas in the stomach. You will not have collapse or shock with gas in the stomach as you will with ptomain or leucomain poisoning. Until some one can give us a better term than "heart failure", I do not know what we can do. One doctor says he thinks most of those cases have some heart disease, possibly fatty degeneration. Several of those cases I reported had weak heart, others had not.

Helps and Hindrances to Proper Prenatal Conditions. By W. C. Hastings, of Seattle.

The writer mentioned the necessity of suitable dispositions and mental traits for success in life's work. Father and mother are equally responsible for the character of the child. The child is born defective and degenerate owing to the parents being alcoholic, neuropathic and sensual. Sexual crimes are increasing but only a small number of them can be combatted legally. The mother cannot control the fetus in utero physically but maternal emotions can, to a certain extent, affect the mental development. The environment of the pregnant woman should conduce to cheerfulness and equanimity. The parent's self-indulgence and peculiarities of temperament may be intensified as mental or moral degeneration in her children. It is the physician's duty to point out and urge such means as to prevent such results. Whatever conduces to the health of the mother leads to the growth and development of the fetus. Her diet and exercise must be regulated and any diseased condition properly treated. The germs of various contagious diseases can pass through placeuta, from mother to child. Tuberculosis, syphilis and rachitis were discussed and their proper treatment mentioned.

Grant Hicks, of Tacoma: The doctor has not exaggerated, if anything he has underestimated the impressions made on the mother while carrying the child. I think he has not dwelt sufficiently upon the subject of pre-natal deformities. That is a subject I think we should all consider, that we should almost legislate against—cripples walking upon the street, and upon the street cars, where they are exposed to the sight of the prospective mother. In the breeding journal there is recorded an authentic case, following the war of 1864, where a band of U. S. army mules was put in a field. On the shoulder of each mule was recorded the letters "U. S." In this field there was a red cow. When this cow's calf was born, "U. S." was on the cow's calf, on the same shoulder. That came through as authentic a breeding journal as we can get; it is a matter of history. That was followed down for four generations, and there were still markings. If that is true, and we have veterinary surgeons to support this statement, why do not mothers get the same impressions that make the physical impression on the child? We know we have such cases. There is a case at home of a cripple selling lead pencils who had a crippled hand in which he used to hold the pencils. An Italian woman's child was born with an exact duplicate of that hand. Another case, a butcher cut off his finger; when his son was born that same finger was amputated. Following the birth of that child there was another and the same finger, another finger, and two toes were amputated. That is a family we know in Tacoma. If we can say that had anything to do with it—and I claim it has—why should we allow cripples on the streets? We should not permit the would-be mothers to become exposed to such sights. I do not suppose that in one case in five thousand the child will be marked, but if a cow can have a mental impression, so strong as to mark her calf, so can an intelligent mother.

Kenelm Winslow, of Seattle: I know of a woman exposed to a bear and when the child was born it was bare headed, bare backed and bare all over.

L. R. Markley, of Bellingham: It is hard to keep all the people off the street who have lost a finger or toe. A few days ago a case was reported of facial cancer, through our chief of police. A man was walking the streets with half of his face gone. I told the chief the man ought to be taken off the street. He said, "Why?" I said, "If your wife were pregnant would you want her to see this man?" He said "No." I do not believe we should allow them to walk the streets.

C. A. Smith, of Seattle: I am surprised in this day and generation to hear people advocate this theory in cold blood. I supposed these were known to be mere imaginations in women's minds. Embryologists have proven to us that the physical features are firmly established at the second or third month. Nothing has any effect upon them after that. Extensive examination was made not long ago on this score. Many mothers were asked to state if they had any reason to suppose the expected child would be marked from anything they had seen. They nearly all had seen something. Not a single case was born with any such deformity as anticipated. I believe it is absolutely impossible to transmit abnormalities. I do not believe a reasonable man has any right to entertain such a thought for one moment. My view is that this whole matter of maternal impressions is an absurdity.

P. W. Willis, of Seattle: I approve what Dr. Smith has said. I had something rather apropos of this recently, in a personal injury case. A woman sued the Seattle Electric Company because she was delivered at nine months of a monstrosity. A great portion of the head was gone, and there was spina bifida. At five months pregnancy she had been thrown down in a street car. The woman previously had had eleven normal children; this one came by breech. Those facts going before a jury were pretty sure to put the blame on that fall. I looked up the facts and found that spina bifida occurred at the second month; the spinal column was normally closed before this accident occurred. Consequently the jury looked at it in that light and the verdict was against the woman. To be sure that I had not given prejudiced testimony I wrote to Dr. Hearst, of the University of

Pennsylvania who said there was no question that the spina bifida occurred long before the accident. Take one hundred pregnant women and I would be willing to guarantee they had seen something that had caused a maternal impression. When we find any one that has a monstrosity it is very easy to find something they can trace it to.

Dr. Hastings, in closing: I wish to say that in this discussion I do not believe my paper has been touched upon. It has been more in reference to something I did not have in the paper. I did not intend to convey the idea that there were maternal impressions or goose-berries or anything else of that kind. Of course we have biblical testimony in reference to maternal impressions; that you can receive or not, just as you please.

Chorea in Pregnancy. By J. M. Semple, of Spokane.

The death date of this condition is 17 to 36 per cent. Some claim the cause is always of nervous character, others say it is infection, others give it as always secondary to endocarditis with cerebral embolism. The usual symptoms of these latter conditions may or may not be present. The majority of cases occur for the first time in primiparae, with whom the first pregnancy is most subject to infection. There is a predisposition in some cases. It is most common during first three months of pregnancy. Mental disturbance more often takes the form of mania than in children. Treatment is like that of childhood with added question of induced labor. Arsenic is of most value unless patient is rheumatic. Bromide and chloral are of use for nervous conditions. Induce abortion in aggravated cases but do not wait too long. The disease occurs once in 1000 pregnancies. The writer has had two cases during the past eight months. The first was three months pregnant. She did not follow treatment advised. In a month she was in condition to demand an abortion. She died four days later. The second case developed the disease at about the second month of pregnancy. Treatment caused no improvement and abortion was induced. She made a good recovery.

W. C. Heussy, of Seattle: The entire absence of any positive ideas of the etiology and pathogenesis has distinctly handicapped the treatment of this disease. There is no disease of the nervous system so manifestly aggravated by pregnancy as it. I believe a very severe case in the early part of pregnancy a sufficient cause for the production of abortion, or premature labor. Coming on in the latter part of pregnancy I would let it continue; but in the early part I would not; the mortality of eighteen or twenty per cent is evidence enough for that. I do not think it is a neurosis, as the patient, if she does not get better, is not troubled with it again; it is not infectious; there is no fever, although we do have heart complications. The chief difficulty in diagnosis is in differentiating between true chorea and that of pregnancy. In the hysterical form the movements are sudden, isolated and often rythmic. Emptying the uterus in connection with iron and arsenic has a quieting effect.

Report of a Case of Hemorrhage into an Ovarian Cyst. By G. W. Libby, of Spokane.

Patient of 48, mother of one child, began to mensturate twelve hours before the doctor was called. At this time had grave abdominal symptoms with hard tumor in left iliac region. Symptoms of hemorrhage were present. Diagnosis of ruptured tubal pregnancy was confirmed by consultant. Immediate operation advised but refused. Two hours later it was performed. A large monolocular ovarian cyst was removed, distended and black with blood. Convalescence uneventful.

R. C. Coffey, of Portland: I believe this case was probably extra-uterine pregnancy, rupturing into the broad ligament. I have seen two cases of extra-uterine pregnancy in which rupture did not occur into the abdominal cavity but into the broad ligament, one being brought for operation in a dying condition, in which an abscess had ruptured into the rectum. On opening the abdomen it was found the abscess was primarily in the broad ligament, and the remains of the fetus were in this sac.

Dr. Libby said, I do not see how it could have been possible for a rupture of that tube in the condition in which we found it. It was very much thickened and formed part of the wall of the cyst; the ovary was almost entirely disorganized, and no ovarian tissue left. There was no appearance in the broad ligament of anything except a general infiltration; no distinct clot, but the pedicle formed by the broad ligament merged into the wall of the cyst.

The Clean Milk Problem. By Kenelm Winslow, of Seattle, Secretary Laboratory Committee, King County Medical Society. (See page 15.)

AFTERNOON SESSION—3:30 O'CLOCK.

Woods Hutchinson, of Portland: This question needs to be approached from various points of view, and the first objection met with in the attempt to improve the quality of the fluid consumed under the name of lacteal fluid is, "Why can't you let well enough alone? Here is milk and here its natural surroundings—dirt. The two get a little mixed but what harm does it do?" There is an important offset to that argument, and that is milk drinking is an artificial taste. There is no such thing as milk drinking by adults in any other form of animal life. We are creatures of civilization; civilization must protect itself from its excesses. There are more bacteria to a cubic centimeter in milk than there is in a city sewer. How can we consume this unless we take some means to protect ourselves? The milk placed upon the market is usually swarming with germs. The only limit we are able to place is that the wretched stuff shall not contain more than five hundred thousand germs per cubic cc.; that is, more than 2,000,000 to the teaspoonful. Can you imagine anything more objectionable, and yet that is the standard for clean milk. The redeeming feature is that most of these bacteria are pretty good friends of ours. We are beginning to find that we are surrounded, not with the powers of darkness, but with the powers of light. A way out of the situation is to control the production of milk as suggested, and I agree with Dr. Coe that Portland is not so badly off. We are endeavoring to solve the problem simply by offering a premium to the clean daries; adopting a system of certificated milk; and an inspection is made of any dairy which will agree to comply with our conditions. The place is inspected, the cattle tested, the milk examined bacteriologically, and tested for butter fat; the surroundings, water supply and everything taken into consideration, and if found o. k., then a certificate is issued that the milk is produced under practically ideal conditions. Although we have only had that plan in operation a short time there are two dairy men milking a total of about 100 cows who have come under this agreement, and their places are really as clean and as satisfactory as a dairy can be made. The cattle are milked in a special room which has a water proof floor, and a hose in constant readiness; every bit of soil is removed instantly, the cattle are groomed, and the udders are carefully washed; the milkers wear white suits, wash and sterilize their hands; the milk is taken to a spring and cooled within twenty minutes; placed in cans and distributed to consumers within twelve hours. Tests which we have made fourteen hours after milking have shown, instead of half a million germs, but 3,500 in one case and 1,750 in the other. It is a thing which is within reach. All you have to do is to be perfectly clean. I believe you will find in your work here that the adoption of something of that sort would be of great advantage. Of course, that is only for the higher class of dairymen. Then there is the other method if insisting upon a certain minimum of cleanliness or rather uncleanliness—no milk allowed to be sold in the market which has more than 20,000, or better, 100,000 bacteria per cc. I believe it would lower infant death rate and save more lives than any other method within the reach of the medical profession.

David DeBeck, of Seattle: I do not believe we can get any reforms in this country until you can show that a reform pays. We are so prone to rely upon law and restrictions, it seems as if our experience can teach us nothing in this. I think it can be shown that this will pay. If you will get the May number of Country Life in America you will find there an illustrated article by Professor Bailey of Cornell describing a dairy farm in New York State and incidentally giving some points as regards restrictions in the east.

P. W. Willis, of Seattle: I think our State Association ought to act in this matter. I move that a committee be appointed to act during the year and to report at our next meeting what they have done, of which our President shall be chairman, and that he shall make the committee as large as he choses. Motion unanimously carried.

Injuries of the Spine with Report of the Case. By W. C. Cox, of Everett.

If the injury is above the fourth cervical vertebrate, death follows; above first dorsal, paralysis of arms; below this, paralysis of legs. Location determined by motor and sensory paralyses. Treatment aims to relieve the cord and immobilize the fracture. In partial lesion operate at once, in fracture of laminae, operate; in complete transverse lesion operation is contraindicated.

A man of 39 was crushed by heavy timber, dislocating 9th dorsal vertebra and fracturing 2d and 3d ribs. Extension and manipulation gave partial reduction. At first was paralysis of extremities, bladder and rectum. At end of two months he could walk somewhat. At end of a year he could walk only with canes; could not work; wore stiff jacket.

J. P. Sweeney, of Seattle: One case I have had under observation since March, 1898. Man, 21 years of age, in good health, perfect physique, good habits and was seeing people at the Yesler power house about electric supplies. As he was about to get on one car another struck him in the back and turned him around, and as he fell his head struck the foot board of the car. There was considerable shock. From examination 1 found crepitus. The arm or leg centers did not seem to be disturbed. The right half of the field of vision in both eyes was affected; the right eye recovered promptly, but the paresis was manifest throughout the body. Moving the head gave him great pain; I could not examine it sufficiently for the reason that there was a large mass of blood at the back of the neck where this injury had occurred. It was one month before I could press deeply into the place, and I found even then crepitus, and the head would get out of place. The moment he would arise from a horizontal position there was vomiting. I characterized it as fracture of the 4th cervical with crushing of the third, but the spinal cord was not cut. Whenever the head would get out of place there would be general paresis. One night the nurse telephoned that he was dead. I found no motion at all, arms and legs completely paralyzed; hyperesthesia and anesthesia in various parts of the body. The case progressed until finally there was atrophic neuritis. I have heard of him once since. He is now in business. He was 62 days in a prone position and then I had him put in a chair and gradually brought into an upright position. The moment he was moved from a horizontal position he would get the hiccoughs.

Dr. Williamson, of Portland: If we were to be guided by symptoms presented immediately upon injury we would always be induced to operate. The results would often be unsatisfactory and deplorable. If there is traumatism sufficient to do any violence, we have to approximately determine the degree of damage. The first point is to see whether there is any diminution of symptoms and if they steadily decline it is unwise to operate, because in such cases, if delayed to a point where there is cessation of improvement, it accomplishes all that is desired. In the majority of cases, the case goes on to recovery without operation, and this eliminates the danger which always attends these operations. I would take the course suggested by Dr. Cox, believing that it would give the best results in this case.

Report on the President's Address. By H. M. Read.

The Committee, to which was referred the President's address recommends that the president's suggestion be approved and referred to the Committee on Revision, for incorporation into the constitution that a committee be appointed to furnish a yearly list of ten physicians, who, in the language of the law, "shall be skilled in the profession," and from which the Governor of the State may select appointees for the State Medical Examining Board. It was moved and carried that this resolution be adopted.

Dr. Read also said, This committee would further recommend, relative to medical education in this state, the adoption of the following resolution.

WHEREAS, It has come to our knowledge that there is a movement in progress in the University of this State, looking to the establishment of a pre-medical course in the University of Washington, which course is designed to secure to the student therein full credit for two years in any regular medical college; and since recognizing the splendid work done in the Arts and Sciences by the present faculty, under the direction of its able President, we deny the fitness and ability of non-medical men to furnish the proper instruction with the equipment at hand that the state is at present able to furnish; and whereas there is no demand for such a medical course or medical department in our University on account of a surplus of medical schools in the United States, BE IT RESOLVED, That the Washington State Medical Association is opposed to the present or future establishment of any course of medical instruction in the University of Washington until such time as the community becomes large and populous, and the state is endowed with sufficient wealth to furnish an equipment second to none in the United States. And

BE IT RESOLVED, That his Association is against and will firmly oppose, with every means at its command, the establishment of any medical school whatever outside of the State University. Further

BE IT RESOLVED, that an effort be made to secure legislation which will place for all future time the medical education of this state absolutely under the control of the State University.

The motion was unanimously adopted.

Dr. Read said, It is a well known fact that the country is filled with incompetent nurses. I would suggest the appointment of a committee of practical medical men to confer with the best element of the nurses in this state to see if some influence can be brought to bear in the Legislature toward making a standard for nurses along the same lines as for physicians.

A. H. Coe, of Spokane: I think we are particularly unfortunate in regard to training schools for nurses. I happen to be a member of two institutions where there are so called schools for nurses, and only last year I refused to sign diplomas of some nurses. It seems to me that work should be directed toward the governing boards of the various hospitals. I think good might be accomplished by the appointment of a committee whose duty it should be to write to the several training schools in the state and determine what at present their qualifications are for admission, the length of the course, the requirements for graduation and so forth. After these points are obtained some definite plan could be outlined by which the requirements could be elevated, and we would secure a better class of graduating nurses.

F. H. Coe, of Seattle: If a committee can be appointed that will take up that study during the ensuing year and formulate some recommendation that can be taken up at our next meeting, I think it would be advisable.

Dr. Read moved that such a committee be appointed. The motion was carried.

EVENING SESSION—8 O'CLOCK.

The Electrical Treatment of Chronic Constipation. By J. R. Harvey, of Sunnyside.

Either galvanic or static current is used. With the former the electrodes are placed about three inches apart over the colon and moved in the direction of the fecal movement. With the static machine a metalic electrode is inserted into the sphincter and the current applied. Three cases were reported. One was treated for ten minutes with the galvanic current and the bowels moved next morning. Improvement continued permanent after four treatments. The others were improved, one by static and the other by the galvanic current.

F. A. Churchill, of Seattle: I have used the galvanic current with one pole in the rectum and the other along the course of the colon with some success. I had an old lady, 70 years of age, had been constipated all her life and used cathartics constantly. I used upon her static electricity and interrupted current, in much the same way as the doctor describes, without the slightest success.

Thos. Parker, of Toledo, Ore.: I have had a little experience in treating chronic constipation by electricity, galvanic and faradic currents, which has been a failure in the long run, unless I also used massage of the abdominal muscles. I found from experience that the exercise of rowing was the best of all ,providing the patient were able to do it.

Frank, of Yakima: I have perhaps the first static machine ever introduced in Central Washington, but I have never realized any benefit from it. Patients get tired when they have to come every day to the office for treatment, and I have not seen the slightest improvement from the use of electricity. I am glad the doctor has done better than I have in the matter. I have had patients as many as thirty days and some longer. I always came back to the old treatments, with massage, washing out the colon, etc.

Dr. Harvey, in closing: I wrote this paper with the expectation of gaining some information on the electrical treatment of chronic constipation. I do not come here claiming to know all about this treatment by any one method. This has proved successful in my hands and I am somewhat enthusiastic. Any one can become constipated a second time, but the results that I have secured have proved more satisfactory than any other method of treatment that I have ever used.

The Prophylaxis of Syphilis and its Sequelae. By. Wm House, of Portland.

The doctor touched upon the prevalence of the disease and drew attention to its frequent origin from non-veneral sources. He cited a number of cases illustrating the more common modes of contagion. Methods of prophylaxis are by legislation tending to limit prostitution, to prevent marriage of syphilitics, to prohibit their employment in certain occupations, and to enforce precautions upon those infected, making the disease a notifiable one. Educational methods include instruction of adolescents in sexual matters, and aim to teach syphilitics how to prevent conveying the disease. Treatment, properly pursued, is a great aid in prophylaxis and must be vigorous and prolonged. Of all methods that by education is most likely to yield good results.

Humanity and Common Sense Versus Idealism in Venereal Prophylaxis. By G. S. Peterkin, of Seattle.

The paper emphasised the following points;

Veneral diseases are detrimental to the evolving of every individual.

The object of veneral prophylaxis is to aid all humanity in its evolutionary advancement.

Prostitution and veneral viruses cause veneral diseases.

Prostitution has existed always, and will continue to do so indefinitely.

Every human being possesses the absolute right to make his own morality and, as a woman is a human being, she has a right to prostitute herself as well as man.

Man does not posses the power to create, control or destroy eternal organic laws of nature, by means of statutory or constitutional laws of his own creation.

Prostitution is dependent for its existence upon an eternal, organic law of nature, essential to life. The sexual instinct is given to man for two reasons, to perpetuate the species and to rivet the tie between husband and wife, not only by offspring but by mutual endearment.

Veneral viruses are potent instruments in the law of evolution, created by nature as a protective force to defend the law of sexual instinct from transgressions of perversions of its principles. They act by aiding the fit to survive, by destroying or rendering sterile the unfit and the ignorant.

Total supprèssion and reglementation of veneral diseases are "hygienic idealisms" because they demand constitutional and statutory laws, built upon premises that are contrary to the organic evolutionary law upon which they depend.

Education of the individual is the means of success.

G. W. Hawley, of Seattle: In regard to legislative prophylaxis, I agree with Dr. William T. Bellfield of Chicago, who recently said that we have only to take example from European countries that legislative means are practically of no avail. As he points out, our first means of going at this question is in education. It rests with educational means to bring young boys and girls to a proper and clean view of this subject. As soon as those things become known they become common place. Just as soon as the mysteries of the sexual relations become known the curiosity will disappear. I would like to take exception to what Dr. House said in regard to the percentage of cures of syphilis. I believe it is curable in a certain limited number of individuals. I think the cure rests largely with the pre-disposition to the intake of mercury. Those who can take a large quantities without marked effect certainly have a fine possibility of cure but there are a considerable number of who have a small intake of mercury in which cure is questionable, and I think that we have to look to the neurologists principally and the internal medical man for the statistics of cures.

Woods Hutchinson, of Portland: I think these two papers have brought before us one of the most important subjects which could possibly engage our attention for two reasons; one is that at this point we begin to be able to demonstrate the physical basis of morality. Most of us believe that morality has a physical basis in almost every instance, and in fact morality as we now understand it is merely that line of conduct which experience of past generations has proved to be the most advantageous, either to the individual or to the race. I take my own share of responsibility in saying that we have not lived up to our responsibility in this regard. The reasons why we have not done so are clear enough; part of them not altogether discreditable, because we object to speaking upon such subjects in public, and I think that feeling to a certain extent accounts for the slowness with which we have taken up this discussion. We have the sort of feeling that ignorance of these things is innocense and righteousness, and if we can only keep these things out of sight that some way or another everything will come out all right. The time for that sort of thing is past and the time has come in my judgment when every member of our profession should be a teacher of moral and sexual righteousness, and that we should tell to every one that comes to us precisely what is the nature of the obligation of sexual purity, and why it is as absolutely obligatory upon man as upon woman; that there is one standard and one standard only for both sexes. I made a study some years ago of the problem of prostitution and the result I arrived at was that regulation and inspection of any sort does simply nothing except attach an air of respectability to the whole performance, and to give the state a feeling of false security which simply results in a wider spread of venereal diseases. With modern methods, with careful intelligent warning in advance of what the dangers are and the warning of the individual who has become infected, I believe the disease can be absolutely stamped out, and absolutely limited, and ours is the profession that can lead in this direction. One word in regard to our duty toward the prostitute. There is no doubt that if we could reform the prostitute and cause her to become a mother of children, it would be a curse instead of a benefit. We can well afford to spare her and she had better be dispensed with. As a rule prostitutes are not recruited from any respectable branch of society. It is a trade which sterilizes the woman who follows it, and sterilizes a large number of men who consort with her. I think we must agree with Lincoln in his discussion of prostitution, that she is in some way a necessary evil, and that she is to some extent a necessary element for the institution of monogamic marriage. She stands there at the parting of the ways, accursed for the health of the nation, and smitten for the sins of the people. We may condemn her, but we must pity her and it is our right, and our duty to treat her just as we would any one else who is suffering and in need of our care.

C. W. Sharples, of Seatle: I have very little belief in moral education as a matter of prevention of syphilis. It makes no difference how good people are, they still have the sexual instinct, and there are a considerable number in whom it is dominant and cannot be controled by education. The ordinary prostitute does not come from a family of high moral tone, but from the class which breed criminals year in and year out, perhaps not gross but petty criminals. Until such time as the confirmed petty criminal is exterminated we will still have prostitutes in the community. If the people of this country could see the necessity of preventing the propogation of petty criminals and of people with bad hereditary physical taints, those things that cause general degeneration of the race, we would have a better race physically, mentally, and morally. Personally I am a firm believer in the matter of desexualizing of all confirmed criminals, and in addition to that, criminals against morality.

A. H. Coe, of Spokane: The fact that the great majority of prostitutes come from the criminal class leads us to the question what character of men patronize them. The great majority are not from the best families of the land; they are men in the same class with these prostitutes. They are of low moral tone and of the same breeding. The question comes up as to education. What good does it do to talk morals to them? The only thing is the question of self preservation. Place before them the results of impure intercourse, of infection from these women, and you touch these men in tender spots. The question of morals will have no effect at all, but if you get to what the results are going to be you will reach them. The education which we may direct toward the young man of this country, and if necessary, the school children, must be very largely on the points of the results accruing to them from intercourse of this kind.

J. C. Moore, of Seattle: One point in regard to education. I do not think that telling a young man he is going to avoid disease by a certain course of action is going to cure him. The country is filled with literature from quack institutions setting forth half truths which do a great deal of harm. I take issue with Dr. Coe that all men who consort with prostitutes are of the same class. Many men believe that a certain amount of intercourse is necessary to health. They do not know that nightly emissions are nature's method of regulating things. We know men of intelligence who believe they are diseased because through living a continent life they have these emissions. We should speak more freely of these things to our patients and educate them and let them know this is not a disease.

G. S. Wright, of Friday Harbor: I take issue with Dr. Sharples on the question of moral training. I do not believe moral training in the line of preaching is of any value. but I believe that early teaching is the great thing. The boy and girl get it early from some one. Let them get it from the right one. Surely getting early instruction from the mother, the father, the family doctor, would save many men who do not naturally belong to the criminal class.

F. H. Coe, of Seattle: Dr. Weed, now resident of California, left in this city a pathologic specimen of a man who died at Providence Hospital of syphilis. He had a gumma covering almost the entire skull. The skull is perforated through and through, eaten out, base, walls, vault,—holes you can look through. Not long ago a young man came to me and said: "Do you remember the time you showed a lot of us boys that skull and told us what it was?" He said, "It had more effect on me and on the other boys than all the teaching you could give us." Almost all of you will get hold of a syphilitic specimen of some kind. If you will take your young men friends, gather them about you, talk with them upon these subjects, you will find that you will do more to educate the public against the evils of syphilitic infection than in any other way.

L. R. Markley, of Bellingham: I secured an atlas on venereal diseases and have shown the illustrations in that book to young men, telling them the evils of syphilis, and I can assure you it makes a very vivid impression, and I believe is a good method of instruction.

Wm. House, in closing: There is only one method of lessening syphilis and that is education. Causing the arrest of and enforced confinement of individuals suffering from this disease is looked upon as almost useless so far as immediate reults are concerned, but it is educational; it forces upon the community the idea that this is a thing about which they must be careful. I do not suggest restriction or medical examination, but I do say that it is necessary to keep prostitutes off our public streets and to make it apparent that they may live in certain districts unharmed by the police, but in other districts they cannot go. I advocate that they be seggregated and the notorious assignation houses be closed. We must begin in our public schools. We must divide our classes according to sex, and have teachers who have no other connection with the school. Decent, cleanly instruction needs no defense. It will not be necessary to give it to the girls, in most cases it will be sufficient to give it to the boys. Education must be the key note.

Gastro-Enterostomy and the Elastic Ligature. By C. A. Smith, of Seattle.

The indications were given for the operation and the symptomatology described. The history of its development was given and the various methods of its performance, with arguments for and against different features connected with it. The general steps of the operation were detailed. The history and development of the elastic ligature operation was presented and its technic described. A series of animal experiments was given, and the specimens exhibited, illustrating various methods of operating. Especial attention was directed to those done with the rubber ligature. The defects of the operation were mentioned. The writer concluded that this is an efficient method but he would reserve it for cases of emergency, where time-saving is necessary, ordinarily preferring the incision and ligature method. He described two operative cases with the elastic ligature.

R. C. Coffey, of Portland: The specimens which the doctor has presented are very interesting, but they are incomplete in that they do not show final results. However, this is the only way in which we can judge the results of these various operations. The tendency of the gastro-enterostomy is to close up. Now there is a question brought up by these specimens of Dr. Smith's, namely, what is the result in a few months? This elastic ligature is becoming very valuable because applicable to so many conditions. One of the most frequent conditions for which gastro-enterostomy is used at the present time is ulceration of the duodenum. As far as the immediate results of this operation are concerned, I believe it is all right. As to remote results I believe nearly all cases will close. Instead of the ligature it has been found that a silk thread produces the same effect, especially where they undertake to make a quadrilateral opening. If it produces the same effect to put the ligature through, why would it not be just as well to take up a bunch of the side of the intestine, ligate it thoroughly on each side, then cut it off and suture around? In that case we do not touch the inside of the intestine. I believe the through and through ligature is the ideal. Surgeons are gradually and surely coming to the adoption of the simple suture; that we are using today various mechanical devices for this intestinal suture simply because we have not experimented and thus perfected the technic. All kinds of fancy stitches and various schemes have been tried, but it has come to the point that the bringing together of the two surfaces and retaining them with a through and through stitch is the best mothed.

THURSDAY, JULY 14th.

MORNING SESSION—9:30 O'CLOCK.

Clean Milk Committee.

The following were appointed by President Coe: K. Winslow, of Seattle, chairman; Geo. A. Gray and W. W. Potter, of Spokane; J. P. Sweeney and G. B. Mculloch, of Seattle; L. L. Love and G. S. Hicks, of Tacoma; S. B. Nelson, of Pullman; W. S. Wells, of Yakima; H. A. Thompson and L. R. Markley, of Bellingham.

F. H. Coe said: I suggest that Northwest Medicine print at once the address of Dr. Winslow, and that the Association authorize the purchase of 500 copies of the paper for distribution, under the direction of the committee. A motion was passed that a sufficient number of reprints of Dr. Winslow's paper be gotten out and an allowance for postage be made for distribution of the same.

Report of Committee on Prophylaxis of Venereal Diseases. By G. S. Peterkin, of Seattle.

A statement was given concerning the prevalence of venereal diseases and official measures to suppress them in different countries. A report was made of circulars to this end sent out by this committee throughout the state and its purpose to continue this work.

A motion was made that the committee be made permanent.

Wilson Johnston: I propose an amendment to the above motion, that the committee be allowed $50 for expenses of literature in furthering its purpose. They have already gone to considerable expense, and if they are continued as a permanent committee they should be allowed an appropriation for expenses.

David DeBeck objected to circulating the pamphlets to physicians on the ground that it is an insult to them as physicians.

Dr. Peterkin replied: Our idea is simply to put the literature in such form that physicians can have it at hand in a concise form to base an argument upon to their patients, the clergy, and to others whom they may wish to educate. These pamphlets are the work of men who have taken the best information on this subject, and given it in such form as to be readible and convincing. If things are put in such form that a man can see it in a scientific light it will in the majority of cases prove convincing. Often a busy practitioner has no time to look up authorities, and many people refuse to be convinced except upon authorities, and they want it in such form that they can take it home and read it.

Dr. Read added: You cannot do this without having physicians accept it as a personal matter to themselves. We believe that we personally are as able to conduct reformation in this locality as those who would send us the literature. Therefore, I move that this is unnecessary and uncalled for.

Wilson Johnston, of Colfax: I am glad to see the Society getting so tender. Evidently for years we have been callous because for years we have accepted on tuberculosis the very class of literature which we are objecting to accept on venereal diseases. I must say to me it is no insult to have laid down before me clearly and precisely the precautions a patient should take against the spread of disease. I was glad to have literature on tuberculosis. I found it a convenient method to be able to open the drawer, take out these rules and hand to the patients and say, "Here is the best that the committee of the Washington State Medical Association can give you." I know these things myself, but I have not the time to sit down and write them.

F. H. Coe: I recall the meeting in regard to tuberculosis when we met with intense opposition. That committee published pamphlets which have been out for the last five or six years. It never occurred to a single man in this convention that there was any dictation to him because he could pull out his drawer and take out a pamphlet which said "You must not do this or that." This circular is merely to put into his hands in a concise form to use as instructions to give to his patients.

J. A. MacKinnon, of Seattle: I have handed to many men a printed form, simply a little slip stating what to do and what not to do. It was a very sensible thing to give them. If these printed rules will be the means of limiting the infection among some they are worth while.

Dr. DeBeck said: I have not felt disposed to question the work of the committee. I do not know what it intends to do, but I would like to see what it accomplishes; then the question can come up as to what is to be sent out and where. I move a substitute for this motion: That the committee on prophylaxis as now constituted be made permanent.

Wm. House, of Portland: If I return to practice and find myself unable to obtain such slips as Dr. Peterkin advocates I propose to compile for myself certain information in a concise and definite form on prophylaxsis, to be handed to patients to emphasize the necessity of morality and continence as essential to decent living. I think those two slips rightly used cannot help but be of vast benefit. Education is in my mind the only means we have of combatting disease of any description.

President Coe said: It is moved that this committee, consisting of E. M. Brown, of Tacoma; W. S. Durand, of Everett, and G. S. Peterkin, of Seattle, be made permanent, and that an appropriation of $50 be made for their expenses. Carried.

Dr. E. E. Heg, Secretary of the State Board of Health, read the report of said State Board of Health.

Report on Revision of the Constitution and By-Laws. By J. B. Eagleson, Chairman.

It was recommended that no changes be made in the Constitution.

It was suggested that the membership of the Nominating Committee be changed so as to include a delegate elected by each county society. After discussion this was rejected.

The following alterations and additions were accepted:

Chap. 6, Sec. 7, amended to read, "All committees shall be appointed by the President except such as the society shall desire to select, or as otherwise provided for."

Chap. 8 is stricken out as referring to a code of ethics that no longer exists.

Chap. 10, Sec. 2, to read as follows: "Charters shall be issued only upon approval of the Judicial Council," instead of Association, so that action can be had in the interim.

Chap. 10, Sec. 5. To the duties of the President is added, "He shall make annual visit to each county society, the expenses for the same being paid from the treasury of the Association."

Chap. 10, Sec. 6. "A member removing from a county shall only retain his membership in such society of the county to which he may move."

Chap. 10, Sec. 8. The following is added: "Physicians living in counties where it is deemed impracticable to organize a society, shall be privileged to join that society most convenient to them."

Report of Nominating Committee.

The following nominations were presented for the year 1905 and duly elected: President, J. R. Yocum, of Pierce county; 1st Vice-President, W. S. Durand, of Snohomish county; 2nd Vice-President,

W. L. Hall, of Spokane county; Treasurer, J. B. Eagleson, of King county.

For Judicial Committee: Wilson Johnston, of Whitman county; Mr. J. Redpath of Thurston county.

Tacoma was selected for the next meeting place.

President Coe introduced Dr. Williamson, of Portland, President of the Oregon State Medical Association, who referred in a happy manner to the friendly relations existing between the associations of the two states. He referred to the meeting of the American Medical Association in Portland next year and gracefully thanked the Seattle physicians for their part in attaining that end. He extended to the Washington profession a cordial invitation to attend the meeting of the Oregon Association, August 30 and 31, which will be held in Portland.

General Pathology and Diagnosis of Benign Diseases of Bones and Joints. By H. M. Read, of Seattle.

The paper pointed out the necessity of a more perfect knowledge of pathology, both for the physician and surgeon, especially the surgeon. The pathology of the more common diseases, as tuberculosis, pyogenic osteomyelitis, gonorrheal arthritis and the arthritis of tuberculosis and pyogenic joint infections were discussed. Exception was taken to the text book terms of osteitis and osteoperiostitis as misleading and not expressing the true pathologic conditions. The remarks on diagnosis were based upon the pathologic conditions and emphasis placed upon bacteriologic examination of all joint effusions when any doubt of the condition existed, and as routine in diagnosis.

F. L. Horsfall, of Seattle: I would like to lay particular stress upon the suggestion that we should endeavor to make ourselves thoroughly familiar with the pathology of joint and bone affections. In the common conditions which concern us, such as gonorrheal arthritis and rheumatic arthritis, we do well to bear in mind Dr. Read's suggestion about making blood counts. Taking various diagnostic signs in connection with this, we are very often able to arrive at a conclusion without much difficulty. Ankylosis from gonorrheal arthritis is not what we expect to obtain, while ankylosis from a tubercular joint is the best possible result we can hope to get. It is well to bear in mind that there is such a condition as absolute periostitis; also ostitis; also osteomyelitis; also another condition which I am sure most men here have seen again and again, panostitis, which takes in every part of the bone. Treatment of panostitis, if diagnosis is made early enough, is arthrotomy and endeavor to save joint if possible.

Dr. Read: I think the term ostitis should be dropped. The bone itself plays absolutely a passive part in its destruction. It is nourished through the circulation of the Haversian canal system. This we know extends to the periosteum with which it is connected by little strands to the periosteum with which it is connected by little strands of connective tissue. To say that a patient has a primary septic periostitis or osteomyelitis, unless you can back it up by microscopic section, is saying a good deal. In regard to treatment by early incision I think it of prime importance to know what the trouble is. I think that upon one point should be laid the greatest emphasis, the examination of all joint exudates when in any doubt as to diagnosis; then treatment will be clearly defined.

Intra-Ocular Tumors, with Report of Cases. By J. A. MacKinnon, of Seattle.

J. W. Bailey, of Seattle, made a report on the pathology of the above cases, and showed microscopic and macroscopic sections.

The case of Georgia A., aged 4, was reported as of interest, from the fact that the growth started in both eyes separately; presenting the typical "amaurotic cat's eye." The age and the congenital origin made the diagnosis of glioma. Microscopically, the tumor substance, consisted of a stroma of large and small round cells with some spindle cells, enclosing many large blood spaces. The extra-ocular-growth, which was the larger, proved also to be round-celled sarcoma. There were no glioma cells found. Jessup could not define the origin of glioma to occur from the nuclear layers because there was a marked dissimilarity between the cells of the new growth and those of the retinal layer. Following Cohnheim, he considers the growth to originate from some developmental embryonic tissue. This could account for both eyes being affected so frequently with separate growths. His specimens proved the growth to be sarcoma and he thinks it should be classified as an endothelioma.

David De Beck, of Seattle: In these cases of sarcoma there are four stages: (1) Stage of non-irritation; (2) stage of inflammation; (3) stage of perforation; (4) stage of metastasis. Ophthalmascopic examination is an easy method of diagnosis. Radical operation as early as possible is important. What becomes of these patients after operation? Many statistics from literature are rather fallacious because good cases only are reported. I have operated upon two cases that were living ten years afterward. The cases that leave the office go to the surgeon. Prognosis depends upon the character of the tumor; if it is soft melanotic round cell it returns more quickly.

Afternoon Session—2 o'clock.

Defects of the Eyes, Ears, Noses and Throats in School Children. By A. W. Hawley, of Seattle.

Among 400 pupils of the city schools examined by the author, over 50 per cent. had adenoids or hypertrophied tonsils or both, and about 7 per cent. had defective hearing or a chronic suppurative otitis media. Among the educated people 50 per cent. or more are found to have refractive errors, while the illiterate pastoral races have very few if any visual dfects. The deleterious influence of ocular defects upon the mental and moral development of scholars was shown by the report of a few cases, illustrating the backwardness of these scholars and the improvement following the correction of their defects.

The detrimental effect of adenoids upon the ears and the physical development, with the consequent mental impairment, was brought out by the report of a few cases, and the benefit derived from their proper treatment. Deafness and aural disease are so closely associated with adenoid vegetations, in children especially, that any involvement of the ears should at once excite suspicion as to the condition of the tissues in the naso pharynx or nose.

The following resolution was offered:

Whereas, The deleterious influence exerted by defects of the eyes, ears, noses and throats of school children upon the mental, moral and physical development is not fully appreciated by educators and the public at large; therefore be it

Resolved, That it is the sense of the Washington State Medical

Association that measures be taken by the State Board of Health, the State Board of Education, all school authorities and if possible legislation be secured, looking to the systematic examinations of the eyes, ears, noses and throats of all school children, that diseased conditions may be found and corrected.

S. J. Holmes, of Seattle: I am not competent to discuss the visual defects of school children, but I think it is well known to all that the report of Dr. Hawley can be verified by each and every one of us. We are all accustomed to seeing the interrupted breathing, also the large tonsils, and we know perfectly well that with obstruction in nasal breathing we must have interference with the general health of the child. We know also that these children go to school year after year and no attention is paid to their condition. It seems to me, as suggested by the doctor, that some examination of such children should be taken up for the simple reason of recommending to the parents that something be done to remove the impediment to these little ones in their educational progress. I would suggest that this resolution be passed as a necessary method and adopted by our state, preparatory to making it a law.

A. H. Coe, of Spokane: The systematic examination of children's eyesight and the condition of their breathing apparatus and ears is very commendable, but ther eshould be some assurance on the part of the Board of Education as to who is to do this work. We had a peculiar experience in Spokane. The Board of Education decided to have all children examined as to eyesight, and a majority of the Board decided to let this work to a manufacturing optician. It is not very hard to understand why the great majority came away with glasses. Many of these children appeared in our offices later, and I can assure you that the great majority of them did not require glasses, and in many cases those that did require them were fitted incorrectly. I was asked to make a short address to the teachers convention in Spokane, and suggested that they, by means of cards, make a rough examination of the children under their care by means of which they could determine, at least in a gross way, cases requiring attention. The majority were eliminated from further examination in this way. In those cases found defective by the teacher the parents should be notified and advised to take the child to a specialist. This eliminated to a large extent the cost of examination. Of course this would not include the question of disease of the nasal passages and throat, which is of great importance and really has more to do with the backward condition of children than the eyesight. I believe that the backwardness of many children depends more on the presence of adenoid tissue in the tonsils and defective hearing, than it does on eyesight. I move that the President appoint a committee of three whose duty it shall be to confer with the State Board of Education and various county boards, with the idea of bringing about some systematic and careful examination of the school children throughout the state relative to the eyesight and hearing and the condition of the nose and throat. Seconded and carried.

The President appointed the following committee: A. L. Hawley, of Seattle; A. H. Coe, of Spokane, Manning, of Everett.

The Treatment of Congenital Dislocation of the Hip. By P. W. Willis, of Seattle, was read by title.

American Contributions to Tropical Medicine. By J. W. Amesse, of U. S. Marine Hospital.

The discoveries in tropical diseases have been made by those of other nationalities. Within the past six years Americans have made notable discoveries. The work of the Reed Commission in Cuba, in 1901, was discussed and its discovery of the stegomyia as the conveyor of yellow fever. The recognition of the hookworm disease in the southern states, by Stiles, in 1902, was described and the economic benefits for coming years discussed. The work of Ashford and King in demonstrating the agency of the hookworm in the causation of anemia in Porto Rico was explained and the great value the discovery should prove to the people of that island. He mentioned the labors of different men in the study of surra and the successful cultivation of the trypanosomes at Ann Arbor from blood agar tubes sent from Manila. He referred to the work of Americans in the study of amebic dysentery, bubonic plague and leprosy.

A. R. Alfred, U. S. Navy: Tropical diseases are in their infancy. There are a great many which are yet obscure. Dr. Amesse has spoken on the labratory instituted at Manila which is very complete, dealing not only with the bacterologic but with the commercial investigation as well, such as analyses of oils, resin, etc. While I was visiting at Canton, China, I became mush interested in the methods of Chinese life. In many places of the city we could look down through the crevices of the flag stones and see the stagnant water beneath. Whereas it is true that cholera makes great inroads among the Chinese, I have often wondered why typhoid fever had not made more ravages among them. The question comes whether there has not been immunity established in this respect. They live in filth—are surrounded by it. A few years ago it was supposed that nearly all the bacteria or the micro-organisms were of a vegetable nature; the malarial micro-organism was supposed to be the only animal one; it has recently been found that the yellow fever germ and I believe also that of smallpox are of the nature of plasmodia.

C. A. Smith, of Seattle: I think this paper a splendid one. Those of us who have been graduates for fifteen years or more have been taught to believe that the source of all original knowledge came chiefly from Germany, and also believed that the Americans did nothing but secondhand work. I think it is well to have thrust upon us once and a while that we have men of original worth and ability and of original knowledge. I do not wish to cultivate a spirit of egotism, but we ought to be able to hold our heads up and let the world know we can do something ourselves. So far as our personal knowledge is concerned we never expect to have any actual experience with yellow fever, but some of these things will come to us;—dysentery and plague will occasionally strike us. We have had a few such cases within recent years by way of Asia. The new methods of examination of blood, feces ,etc., will furnish information that will shorten disease and save life. The things mentioned by Dr. Amesse are timely and important for us to remember.

Diagnosis of Diseases of the Skin. By R. W. Schoenle, of Seattle.

A description was given of the correct routine for examining a disease of the skin and the line of inquiry to elicit an intelligent history. The value of certain general symptoms was discussed and the significance various lesions. Diseases peculiar to each portion of the body were enumerated and means of differentiating each suggested.

The Early Diagnosis of Tabes Dorsalis. By J. E. Harris, of Seattle.

Historical: First work by W. Horn in 1827. Most important contributions by Romberg 1851, Ducheene 1858.

Distribution: Centers of population and large cities. Men more often attacked than women.

Etiology: Syphilis, trauma, exposure to cold and wet.

Symptom grouping: Symptoms referable to nervous system; lightning pains, loss of knee jerk. Girdle feeling. Anesthesia, Analgesia in various parts of body. Symptoms referable to organs of special sense: Eye, Argyll-Robertson pupil. Occular Paralyses, optica atrophy, Romberg symptoms; ear, taste, smell, show few changes. Symptoms referable to viscera. Gastric crisis; intestinal crisis, bladder disturbances. Symptoms referable to bones and joints: Charcot joint, arthropathy, fractures.

Differential diagnosis: Multiple sclerosis, pseudo tabes of alcoholics. Nicotin tabes, caries of the spine, traumatism. Frederichs ataxia. Special attention drawn to lightning pains and gastric crises.

C. Quevli, of Tacoma: As to the lightning pains, I made the mistake once of treating a case for about six months for rheumatism before I found out it was locomotor ataxia. If a patient complains about rheumatism and looks sporty I think it is a suspicious case. I think there is one symptom that he left out, severe pain over the kidneys. I believe patients have been operated upon for stone in the kidney when it was really tabes dorsalis. There is often intense pain of the urethra; pain in the bladder; neuralgia of the rectum has also been noted. In France it is also claimed that there is metritis of the genital organs.

H. W. Coe, of Portland: In these days, when we are able to do a good deal for this trouble, it is very important that the diagnosis should be made early, before large sections of tissue are involved in this degenerative process. We have had during the past few years a number of cases referred to us, supposed to be suffering from nervous prostration, and this was largely believed to be so on account of the fatigue shown by the patient in walking. A number have turned out to be tabes dorsalis in the early stages. I think the differential diagnosis which the doctor made was very good, also the reference to the differentiation between this disease and pseudo-tabes of the drunkard. The question of syphilis comes in here as it does everywhere. It has been my lot to meet several cases of tabes in physicians where the question of syphilis has been brought in, in whom infection had taken place through examination of patients.

G. S. Wright, of Friday Harbor: I should like to bring up the question as to what is to be expected of children of tabes parents. I had a case eleven years ago with impairment of vision and some other symptoms. The patient is living with characteristic symptoms of this disease. He has had three children, one pair of twins since the disease was well developed. The first is a little girl, deficient in one or two of her heart valves and generally lacking in vitality. The twins are fair specimens of humanity, though one of them has a marked hesitating speech, seems unable to either get his ideas with ordinary rapidity or to express them. I would like to know whether it is common for advanced tabes cases to have children and if so whether it is a rule that the children are physically deficient or not.

Dr. Horsfall said: James Jordan is responsible for the statement that the symptoms of lightening pains, absence of knee-jerk and myosis are sufficient in every case to make an early diagnosis possible in tabes dorsalis. I would like to know from the men who have had a large experience in tabes if that is true.

Atypical and Modified Forms of Typhoid Fever. By C. J. Lynch, of North Yakima.

The paper treated of cases that began as atypical and so remained throughout. These are most frequent during the cold months. They are difficult to recognize and it is hard to persuade the friends of the diagnosis. Several cases were detailed, showing the vagaries of this class. His conclusions are, (1) Our conception of typhoid fever is too narrow; (2) More attention should be given to the atypical forms; (3) The Widal reaction will probably not reach the majority of modified cases; (4) Atypical cases are likely to be followed by relapses of a very serious nature.

H. R. Wells, of North Yakima: I think it will only be a short time until typhoid will be doomed in our vicinity. We have had a great deal to contend with in getting the public to understand the nature of the disease and take proper measures to prevent its spread. There are many mild cases and the people think they have to be very sick. There are many cases of walking-typhoid ,which I think are in a large measure responsible for the spread of the disease.

P. Frank, of North Yakima: I believe that 60 per cent of the cases reported as typhoid in our city were not such. When the climatic condition runs up to 105° and the irrigation problem is considered there must be more or less malaria in the community. When a case yields to ordinary calomel and quinine treatment in a few days I can not be persuaded that it is typhoid, but I must coincide with Dr. Lynch that many cases are typical which have been passed over.

E. E. Heg, of Seattle: In conjunction with the Yakima county and city the State Board of Health is at present conducting a laboratory in North Yakima under the direction of the bacteriologist of the State Board of Health, and I wish to say to the psysicians generally, throughout the state that if at any time they will mail speciment of blood to Dr. Beeb, she will make the Widal test and report the result.

Report of Judicial Committee. By P. W. Willis.

Component societies are required to pay dues before May 1st. The California State Journal wished us to subscribe for their journal, also for their directory of physicians. The committee decided to decline because we have our own local journals and do not care for the directory at present, having our own list of members.

President-elect Yocum took the chair and thanked the Association for the honor of his election. He referred to the coming meeting of the Canadian and Oregon State Medical Associations and urged the members to attend both.

Votes of thanks were tendered the retiring officers; the ladies of Seattle for their entertainments; the visiting physicians from Portland for their presence and assistance. Meeting adjourned.

CHEHALIS COUNTY MEDICAL SOCIETY.

President, D. A. Schumacher, M. D.; Secretary, J. W. Scamell, M. D.

The regular second quarterly meeting of the Chehalis County Medical Society was held July 5, 1904, at the office of Dr. M. Rob. Stappe, Aberdeen, Wash. A fair number was present.

After the usual routine work, Dr. M. L. Pearson, of Aberdeen, gave a short but interesting talk on Pertussis. He thinks the disease can be carried by the clothing of people who have come in contact with the disease. In the first stage there is no congestion in the throat; the whoop is not a positive sign. It is a local and purely nervous disease. The younger the child the greater the danger, as he is more liable to get bronchial pneumonia.

Treatment.—For diet, in older children, fruits, raw and stewed given carefully; bathe them regularly, keep them in the open air much of the time, ventilate their rooms daily. For medicines, give something that will ease the irritation and it must be given at regular intervals; phenacetin in some cases; belladonna; some give the tincture but he prefers atropin, gr. 1-300 to 1-500, 3 or 4 times a day. Never give strychnin to a child, but brucin.

Discussion.—Dr. Stapp spoke on the subject of diagnosis. He always goes well into the history of the case. He said one never finds rales on inspiration, nor after a paroxysm of a cough. This treatment is mercury in the form of gray powder, gr. ¼ every 3 hours.

Dr. Schumacher emphasized the point that the room must always be kept at a uniform temperature, and the air dry, free from drafts.

BOOK REVIEWS.

Edited by
KENELM WINSLOW, M. D.

The Doctor's Leisure Hour. Vol. I of The Doctor's Recreation Series. The Saalfield Publishing Co., Akron, Ohio. 7x10 inches. Cloth, $2.50, 352 pp.

The present volume is the first of 12 which will complete the "Doctor's Series," and the set will be ready for delivery within a year.

The Doctor's Leisure Hour is a collection of anecdotes and funny stories, arranged in a classical manner, according to the object of the tale. Thus we have stories concerning The Student, The Professor, The Young Doctor, The Prescription, The Operation, Some Famous Doctor's, etc.

It may not be amiss to quote some of the briefest: Under Christian Science we find beneath the heading, "An Attraction," the following:

Isaacs—"If I had der time I mighd look into dot Chreestian Zience." Miss Isaacs (astounded) "Vot for?" Isaacs. "Vell, dere seems to be some moneysh in it."

In the chapter styled The Remedy, we find, from a Paris Journal, this quotation. The translation is evidently literal.

First Peasant—"You go to vaccinate your little?"

Second Peasant—"But yes!"

F. P.—"You have much wrong!"

S. P.—"For why?"

F. P.—"There was my counsin who was made to vaccinate the hers—that has it not prevented to die!"

S. P.—"Of the little pox?"

F. P.—"But no! He has himself drowned in the sea!"

Again under the chapter on, The Prescription, we find the following gem, which while not, like the last, from the French, still has a strong Frenchy suggestiveness.

Doctor (to operetta diva who wishes to be vaccinated)—"Shall I vaccinate your arm?"

Diva—"Heavens! No, of course not. Think of me as an artiste with a scar on my arm! You must vaccinate me where it will not show."

Doctor—"I think you had better take it internally."

Under the section devoted to The Student we cull this mot.

Governor of the Prison—"What is the cause of this unseemly delay?"

Jailer—"That expert headsman you engaged from the medical college is sterilizing the axe."

Under Famous Doctors we find that familiar but humorous rejoinder, anent Prof. Wilson, of Edinborough University, who caused to be written on the black board of his laboratory, "Professor Wilson informs his students that he has this day been appointed honorary physician to the Queen." On returning Prof. Wilson found that in his absence a student had written under the announcement, "God save the Queen."

While there is great danger, in making such a selection, of including "chestnuts," yet the present volume has so far avoided such a calamity that in supplying us with the new it may have sacrificed too much of the classical. Thus the admirable little Christmas story of Trollope, describing how a mustard plaster was placed upon the wrong person in a French house in the dark, by an anxious wife, certainly should belong in the collection. The matter is not all of a light character, notably Andrew H. Smith's article on the Family Physician. As a whole, we may commend the book, if taken in small and repeated doses, as a mild and stimulating cerebral stimulant which will not be followed by depression—unless this dose be exceeded. There is an entire absence of vulgarity and the selections show discrimination. To while away the leisure moments of the doctor and to afford entertainment for his waiting patient this book is delightfully adapted.

WINSLOW.

International Clinics. Volume 11. Fourteenth series, 1904. $2.00. J. B. Lippincott Co., Phila.

It is unnecessary to describe the character of this well known quarterly which we have regularly reviewed in the past. The present volume is notable in the following features: The first 128 pages are devoted to a thorough and beautifully illustrated account of diseases of warm climates, including general articles on spread of diseases by insects and recent progress in tropical medicine, and special articles on Sleeping Sickness; Hemoglobinuria; Uncinariasis; Liver Abscess; and on the proper mode of life and treatment to be pursued on a return to a cold climate by those suffering from tropical maladies. These are of special value to all those interested in tropical disorders and are worthy to be preserved for reference. The etiology of hemoglobinuria gives rise to divergence of views; in one article on the subject Wm. Krauss takes the ground that quinine-hemoglobinuria never occurs independently of malarial infection, while Kanellis in the preceeding article maintains that bilious hemoglobinuric fever may be caused by quinine whether the patient has been infected with malaria or not. The discussion is a most interesting one.

Nichols has a very practical paper upon the Etiology, Diagnosis and Treatment of Arteriosclerosis and explains the usefulness of the sphygmomanometer and urges its general employment for ascertaining blood pressure, enabling early diagnosis, and as a guide to treatment and its results. The instrument is pictured and described. Eminently practical articles are Ankylosed Joints and Their Non-Operative Treatment, by Rugh, and Abdomino-Pelvic Diagnosis, by Bishop, of Manchester, Eng., whose two previous lectures on this topic have appeared already in International Clinics. Space does not permit of a more extended notice but we are glad of the opportunity to commend the many contributions of value in this volume and to praise the typography, plates (some of which are colored), and figures, in which the book abounds.

Winslow.

REPORT OF CONTAGIOUS DISEASES.

To the Washington State Board of Health for August, 1904.

Counties.	Smallpox		Scarlet Fever		Diphtheria		Typhoid Fever	
	Cases	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*
Chehalis	0	0	0	0	0	0	1	0
Chelan	0	0	0	0	2	1	0	0
Clarke	1	0	2	0	0	0	0	0
Columbia	0	0	2	0	3	1	0	0
Cowlitz	0	0	0	0	5	0	0	0
Jefferson	0	0	0	0	1	0	0	0
Douglas	0	0	0	0	19	5	0	0
King	0	0	15	0	14	0	2	0
Kitsap	0	0	17	2	4	2	1	0
Lewis	0	0	8	0	0	0	2	0
Lincoln	0	0	1	0	1	0	0	0
Pierce	0	0	4	0	2	0	0	0
Skagit	1	0	6	0	2	0	0	0
Spokane	1	0	4	0	2	1	0	0
Wahkiakum	0	0	0	0	5	0	0	0
Walla Walla	1	0	0	0	0	0	0	0
Whitman	3	1	0	0	1	0	0	0
Yakima	3	0	0	0	2	2	2	0
Seattle (city)	5	0	12	0	32	3	12	3
Spokane (city)	7	3	7	1	22	0	1	0
Tacoma (city)	2	1	0	0	8	1	1	0
Total	24	5	78	3	125	16	22	3
Total June, 1903	114	0	148	4	36	8	12	3
Total 1904	245	6	757	34	625	88	235	61
Same period 1903	655	4	563	12	125	15	0	0

ELMER E. HEG, Secretary.

MEDICAL SOCIETIES.

Name.	Meetings Held.
Washington State Medical Association President, J. R. Yocum, M. D.; Secretary, A. H. Coe, M. D.	1905—Tacoma
Chehalis County Society President, D. A. Schumacher, M. D.; Secretary, J. W. Scamell, M. D.	Second Tuesday—Aberdeen
Chelan County Medical Society President, W. M. McCoy, M. D.; Secretary, H. A. Saunders, M. D.	
King County Society President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.	First and Third Monday—Seattle
Pacific County Society President, G. W. Overmeyer, M. D.; Secretary, Mary W. Gunwell, M. D.	Third Monday of Jan., April, July, Oct.—South Bend
Pierce County Society President, C. Quevli, M. D., Secretary, A. de Y. Green, M. D.	First and Third Tuesday—Tacoma
Skagit County Society President, A. C. Lewis, M. D.; Secretary, R. J. Cassel, M. D.	
Snohomish County Society President, C. A. Mead, M. D.; Secretary, James Chisholm, M. D.	First Tuesday—Everett
Spokane County Society President, G. S. Armstrong, M. D.; Secretary, Geo. A. Gray, M. D.	First Thursday—Spokane
Walla Walla County Society President, N. G. Blalock, M. D.; Secretary, Y. C. Blalock, M. D.	Second Wednesday—Walla Walla
Whatcom County Society President, D. E. Biggs, M. D.; Secretary, W. N. Hunt, M. D.	Second Monday—Whatcom
Whitman County Socity President, W. N. Divine, M. D.; Secretary, R. J. Skaife.	Third Monday of Jan., Apr., July, Oct.
Yakima County Society President, David Rosser, M. D.; Secretary, Carver, M. D.	First Tuesday—North Yakima
Oregon State Medical Association President, W. T. Williamson, M. D.; Secretary, L. H. Hamilton, M. D.	Aug. 30, 31, 1904—Portland
City and County Medical Society of Portland President, R. L. Gillespie, M. D.; Secretary, A. D. Mackenzie, M. D.	First Wed.—Portland
Multnomah County Medical Society President, A. Tilzer, M. D.; Secretary, L. Victoria Hampton, M. D.	First Tuesday—Portland
Montana State Medical Association President. B. C. Brooke, M. D.; Secretary, Grace W. Cahoon, M. D.	1905
Silver Bow Medical Society President, T. J. Murray, M. D.; Secretary, Grace W. Cahoon, M. D.	Second and Fourth Wednesdays—Butte
Idaho State Medical Association President, J. L. Conant, Jr.; Secretary, E. E. Maxey, M. D.	October 6 and 7—Lewiston
North Idaho District Medical Society President, C. L. Gritman, M. D.; Secretary, C. D. Parsons, M. D.	June 9—Lewiston
South Idaho District Medical Society President, H. A. Castle, M. D.; Secretary, E. W. Kleinman, M. D.	Jan. 5, 1905—Pocatello
Canadian Medical Association	Aug. 23, 24, 25—Vancouver
British Columbia Medical Association President, A. P. Procter, M. D.; Secretary, W. D. Brydone-Jack, M. D.	1904—Vancouver
Vancouver Medical Society President, W. D. Brydone-Jack, M. D.; Secretary, J. S. Conklin, M. D.	Vancouver

Corrections and additions to this list are requested from societies reached by this journal.

WALTER T. WILLIAMSON, M. D.

President Oregon State Medical Association

1904.

NORTHWEST MEDICINE

September, 1904.

ORIGINAL CONTRIBUTIONS.

SOME PRACTICAL POINTS IN GENERAL PARESIS.*

By Walter T. Williamson, M. D.
PORTLAND, OREGON.

Medical Director Crystal Springs, Mt. Tabor, Ore., (formerly Mt. Tabor Nervous Sanitarium); Professor of Nervous and Mental Diseases at Willamette University.

We are certainly indebted to the French for the earlier knowledge acquired concerning general paresis. Despite the fact that this disease is almost unique in the faithfulness with which both somatic and psychic features present themselves in its symptomatology,—and also despite the fact that there is a striking sameness in the disorders of the motor system, preserving a recognizable identity,—despite these facts this peculiar disease carved its own way through the ages, usually plainly in sight before smiting its victims with mental and physical destruction, and yet successfully avoided discovery or recognition until the French, only about sixty years ago, began to segregate it from the general mass of mental disorders. As investigation increased, the theories of its identity passed in rapid evolution through first its being a unit, a mental disorder with an appended paralysis; then a duality, a physical paralysis, with an involved mental disturbance; and then a complexity, with an essential dementia, a coincident impairment of motility, and a frequent development of such insane phases as mania and melancholia.

Some difficulty has inhered in securing common adoption of an appropriate name. Perhaps the first name was chronic muscular paralysis; then incomplete general paralysis; then general paralysis of the insane; then arachnitis; then paralytic insanity; then general paresis; and finally, paralytic dementia. If it be desired that the name shall, as nearly as may be, define the essential characteristics of the disease, it would appear that the choice would lie between paralytic dementia and general paresis. That the dementia constitutes an essential of the disease, is admitted, for it is this, and not the delusions, which presents the psychic aspects of the disorder. But the word paralytic, as descriptive of the dementia is open to the objection, if taken literally, of qualifying the mental condition in an unreal and unintended way. The purpose originally was to recognize the dual conditions of paralysis and dementia as elements of the disease; but this duality is only recognized in spite of the title, paralytic dementia, and not because of it. But, accepting the term "Paresis" as defining a condition lying somewhere between the normal exercise of a motor or other function, on the one hand, and its destruction or paralysis on the other, we find a term that usually well describes the entire symptom complex —the mental and the physical. When the range of its application is specifically set forth as being general, including thereby the intellectual, the emotional, the moral, the motor and the sensory, we find a qualifying term of the paresis that, in its combination of general paresis, suggests the impairment or diminution of all the somatic and psychic forces.

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*Read before the Washington State Medical Association, Seattle, Wash., July 12, 13 and 14, 1904.

In bringing to your attention, then, some practical points in general paresis, the first feature will be to remember the vast medico-legal importance of making a diagnosis of this remarkable disease, especially in its prodromal period. If an early diagnosis be made, much distress, disgrace and loss may be averted, not so much perhaps affecting the patient personally, as it does his family and his business interests. Because such cases are not very common in the experience of the average practitioner, it is too often the case that the salient points in the diagnosis are carelessly forgotten, and the symptoms have developed into unmistakable dimensions before the disease is correctly recognized, and by that time the harm has been done.

There are few diseases that have a more gradual inception than general paresis, and even its prodromal period may last from three to fifteen years, and usually its origin is lost in the obscurity of the past. Attention is perhaps first called to a simple intensification or exaggeration of the pre-existing mental characteristics of the individual, and this for a long time may provoke neither criticism nor alarm. Then there may come something of a change in the finer sensibilities, a blunting of that subtle complexity that indicates culture, and which Landon Carter Gray beautifully described as the "finer ethical sentiments which lie on most civilized human characters like the bloom upon the peach." The moral obliquity and intellectual gaps seem to be altogether out of proportion to the general features of dementia. Then eccentrict and causeless acts, lapses of memory, inability to complete, a lack of sequence in undertakings, blunders of every kind, pass in slow procession along the vista of the victim's life, and while his friends are puzzling and wondering at his strange defects in intellection, the fibres of his moral structure begin to disintegrate, and indecorum, negligence, grossness and even wanton visiousness sluggishly enter upon the stage of his existence, and then, and only then perhaps, these friends are startled into realization of some mental disorder. Or this may have appeared as grossness, alcoholism, sexual wantonness, erotism, theft, and other quite pointless crimes. At the same time, or before, he may physically have become inaccurate, clumsy, bunglesome and inapt, and incapable of performing former skillful acts.

Sleep is easily and uncomfortably affected; the physiognomy becomes expressionless, and the evidences of a well-nourished vitality are absent.

Motility and sensibility may be early affected, and these changes necessarily must be interpreted by the physician, being a sealed book to the average layman. The early mental symptoms, on the contrary, being neither classic nor arbitrary are rather dependent for their value upon a comparison with the individual's former self, with his former method of thinking, feeling and acting.

If oculo-pupillary changes be present in the prodromal period, they are of much diagnostic value, and usually consist of myosis, or inequality, or especially immobility, or even of the Argyll-Robertson pupil.

But even yet, doubt may hang on the accuracy of the diagnosis. Progressive dementia points strongly to its true title, and of the further motor symptoms, embarrassment of speech, tremor and muscular weakness are undoubtedly the strongest symptoms. It has been well said, that when embarrassment of speech is absent, whatever may be the other symptoms, we may suspect, but cannot affirm the existence of general paresis. It is the great pathognomonic symptom. Like all the other physical and mental symptoms of this disease, especially in the prodromal period, this speech defect is at first vague and transitory, insidious and remittent. It may be only noticed after eating, much talking, or other fatigue. This speech is difficult to describe, is *sui generis,* and can be easily and early detected by the practiced ear. It is a species of thickness, the sound of utterance halts perceptibly over a certain syllable, hanging there suspended as if from impediment or obstruction; then breaking away from it, the speaker may go on fluently and quite at ease. The letter "R" and the linguals are especially troublesome, and this has suggested phrases such as "truly rural," "artilleryman of artillery" and "blue bottle of blackberry brandy," to test the articulatory powers of the suspected patient. Of the two types, the paralytic and the ataxic, the former is more frequently found in females, and consists of a singsong syllablizing of words, differing from the speech of multiple scleresis in that the latter is more jerky, with the pauses or holdings on the intervals rather than on the words, besides being found early in life. The ataxic speech is confused and blundering, with more perceptible muscular effort, and of more irregular speed, and is more common among men.

The tremor of this disease is rapid, of the class with exopthalmic goitre and alcoholism, and is especially marked in the tongue and facial muscles, the arms and legs, and is among the earliest of all symptoms. This tremor is of much diagnostic value. It is distinguished by being fibrillary in character, of fine, non-rythmical, ataxic type, and it is for a long time intermittent in its manifestations. Protrusion of the tongue out of the mouth may exhibit much of this twitching and, if the patient be requested to hold the tongue still, while projected from the mouth, a jerky, two-and-fro movement frequently ensues, which has been suggestively called the trombone movement from its resemblance to the movements of this instrument while being played upon. This tremor may be determined at an early stage of the disease by placing the tips of the fingers on the dorsal surface of the interdigital folds, and, indeed, the sensation may be so marked as to amount to a crepitation.

Muscular weakness usually asserts itself before long, but at first bears some resemblance to that condition in tabes dorsalis, by really being more dependent upon muscular inco-ordination than absolute weakness.

Another point concerns the knee-jerk. Many authors refer to this symptom as possessing value, but there is a suspicious lack of definiteness as to the condition, to be elicited by percussion, and this is augmented by a discouraging lack of agreement throughout, as to what symptoms, exaggerated, diminished or absent, possess evil significance. The writer may venture to add that after eighteen years of observation of cases of general paresis, first in the State Insane Asylum, and latterly at Crystal Springs, during which time more or less cases have always been under observation, the knee-jerk as an aid in differential diagnosis has practically proved to be of no value. A point of some consequence is the alleged combination of paretic with tabetic symptoms. While some observers have dignified such findings, by attaching the name of tabes to a particular form, it would seem to be true that such cases are rare, and simply indicate the not impossible coincidence of the two diseases.

Another important point relates to a common belief that not only are delusions always present, but also that such delusions are always of the exalted or grandiose type, and accompanied by a sense of "well being." While such is most frequently the case, it is not uniformly so, and the diagnostician must carefully remember that in some cases of general paresis, there are no delusions of any kind, that the sense of well-being may not appear throughout the disease at any time, and even that instead there may be substituted a sense of depression or melancholy. And, again the apathetic dementia which in some degree always accompanies paretic involvement of the brain and cord may be the only abnormality developed throughout. While the plain, ordinary dement of other forms continues by a species of habit, or muscular memory, to do things formerly acquired, as playing cards or billiards, the paretic dement usually cannot, because of defective co-ordination, increased twitching and tremor. This dementia outlines and colors the delusions of grandeur, imparting to them such characteristics as silliness, incoherence and contradiction. Here is a valuable differentiation from the delusions of exaltation of the paranoiac. The latter furnishes a striking contrast, for while rivalling the greatness of the paretic in the magnitude of his conceptions, he is sustained by logical and elaborate theories, fluently offered, that may lend them plausibility and even probability. But the delusions of the paretic are permeated by this dementia and are especially distinguished by one quality, mobility. While the paranoiac will argue earnestly and unconquerably, the paretic permits objection to easily drive him from his claim and position, and some modified absurdity may be substituted.

The etiology of this remarkable disease is not completely established, although syphilis is pretty generally accepted as causation of a greater or lesser percentage of all cases. But it goes without saying that a very large majority of syphilitics do not aquire general paresis, and there are at least some cases of that disease who were not syphilitics. Consequently some other factor must enter into the etiology. Alcohol, sexual excesses and tobacco, without the synergistic action of syphilis, may find such mental or nerve exhaustion as, in some unknown way, to initiate or admit the onset of general paresis. Alcohol alone in excess may cause a pseudo-paresis that for a time closely simulates the genuine disease, and alcohol, syphilis and tobacco have been well termed "the three devils," because of their destroying effects. And it is easily comprehended that when sexual are conjoined to other exhausting forms of debauch, the central neurons must be depleted and robbed of much of their resistive force. But even these are usually accompanied by great mental or nervous strains of some kinds, such as overwork, reverses, worry or disappointment.

Summarizing the points touched upon in general paresis, we find it a disease of duality, or rather complexity, involving the mental and the physical; its etiology, nerve exhaustion with syphilis and other vicious conditions; its early diagnosis a matter of great medico-legal importance, affecting the social, civil and criminal life; its early symptoms somewhat obscure, the psychic revealed by alteration and dementia, and expansive delusions, and the somatic by immobility or inequality of the pupils, by tremor especially of the tongue and face muscles, and chiefly and especially by embarrassment of speech.

REPORT OF A CASE OF PERFORATION OF THE GALL BLADDER IN TYPHOID FEVER, WITH REMARKS ON THE DIAGNOSIS AND TREATMENT.*

By Park Weed Willis, M. D.
SEATTLE, WASH.

The following case of perforation of the gallbladder in typhoid fever is sufficiently rare to be worthy of record.

The patient was a little girl, age 10. She first complained of not feeling well on November 21, 1902. This was Friday, and the following Monday she went to school but felt so badly that she came home. On Tuesday her temperature was 103° and the following Thursday 104°. The next day, one week from the beginning of her illness, she went to bed. My first visit was Saturday, November 29. The tongue was practically normal but later became coated and dry. She had nosebleed frequently during the first week in bed. She slept well at night and was drowsy and sleepy a good portion of the day. The abdomen was normal in appearance but after the first two weeks became more or less distended and this, particularly during the latter part of her illness, seemed more marked on the right side about the lower margin of the ribs. The liver and spleen were both slightly enlarged. Rose spots appeared over the body, especially over the abdominal region, three or four days after my first visit and continued to appear and disappear typically for more than two weeks. The urine showed the diazo reaction on December 6 and was otherwise normal except for a small amount of albumin, December 19. She had almost no cough during her illness. The pulse was at first rather slow but in a few days increased to 120 and a little later to 140 and over. She did not take nourishment well, averaging about two ounces of milk or other liquid every two hours. At one time she complained of pain in the left groin and later in the right arm. She would keep the arm closely flexed and complained very much when it was straightened out, saying that it was sore. For the first several days of her illness her bowels were rather loose, moving two or three times a day. They gradually became normal and then constipated. This was at first relieved by an enema of soapsuds and later of glycerine and sweet oil. On December 22 she was given a teaspoonful of castor oil and this was repeated on the 23d, and in the evening of the 24th she was given one-eight of podophyllin which was repeated in the morning and evening of the 25th. An enema was still necessary and resulted in one fair movement daily.

The treatment consisted in absolute rest in bed with liquid diet and the temperature was reduced whenever above 102°, first by sponging and later by tub baths at 75° F. After running about the normal course the temperature subsided and all the symptoms improved and the temperature became somewhat irregular, ranging from 98° to 101°, the highest being early in the morning or early in the afternoon and it was also higher some days than others. The right side of the abdomen remained a little more full and was somewhat tender at the costal margin. From the 22d to the 25th of December her bowels moved each afternoon with an enema but on the 26th they had not yet moved and the nurse was sitting reading to her while she was lying quietly in bed when, at 6:15 o'clock, she suddenly cried out with pain in her abdomen. The nurse immediately gave an enema of soapsuds with no result except some relief of pain. She repeated it with oil and glycerine and still no result except causing considerable relief. Another enema also failed. She cried with the pain at least one-half hour and then it gradually lessened, but she had considerable until after eight o'clock. After that she had some pain which only occurred when she was moved, after the first severe pain, until 4 A. M. of the 27th when she was very restless with it for one-half to three-quarters of an hour. Her temperature, December 26 at 1 P. M., was 98.5°; at four o'clock 101°; and at 7:30 103°, her pulse being so rapid that the nurse could not count it. At 8:30 the pulse was the same, temperature 105.2°; at 9:30, pulse 144 and about as strong and full as it was for several days previously and temperature 104.2°; at 10:30, temperature 104.6°; at 11:30, 104.8°, pulse remaining about the same. At six o'clock in the morning the temperature was 102°, pulse 120 and about the same in volume. The leucocytes were, at 11:30 P. M., 8,000; 6:45 A. M., December 27, 7,880, and at 11:50 A. M., 17,880.

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*Read before the Washington State Medical Association, Seattle, Washington, July 12, 13, and 14, 1904

When I saw her about nine o'clock in the evening nearly three hours after her first severe pain, she was exceedingly tender all over the abdomen but more so over the right upper quadrant. She was lying with her knees drawn up and had an anxious, pinched expression in her countenance. I told the family it was probably perforation and removed her at once to the Seattle General Hospital. There six other physicians saw her with me. Two of them, with me, strongly urged immediate laparotomy. One advised operation but said it would make no difference, the prognosis was fatal in either case. One was in doubt. One advised to put on an ice bag and wait a few hours for developments, and the other, although he believed perforation was the likely condition, advised strongly against operation. The very great emaciation of the child and her very bad general condition were the arguments used against operative interference. The family under these circumstances decided against operation until about eighteen hours after the first symptoms of perforation.

A general anesthetic was given, preceded by morphia sulphate grain one-twelfth, hypodermically. One-half dram of chloroform was used to start the anesthetic which was continued with ether, of which one and one-half ounces were used. The abdomen was opened by a three inch incision through the right rectus muscle, opposite the umbilicus. As soon as the peritoneal cavity was opened a greenish yellow fluid appeared. There was some inflammatory lymph sticking to the bowels but they did not seem to be very much congested. The lower part of the ileum was gone over carefully but no opening found. The fluid began to look more like bile and there was more in the right side of the abdomen and darker colored in the upper part. Then examination of the duodenum was begun and the gallbladder, considerable distended, began to decrease in volume and, looking on the under surface well down toward the cystic duct, a stream of bile about one half the size of a lead pencil was seen coming from it. Around this opening were three or four small ulcerated spots, each with a diameter the size of a lead pencil or a little less. The bile was sponged out and the peritoneal cavity washed thoroughly with salt solution. This, as usual, improved the pulse materially. The gallbladder, which contained no gallstones, was opened at the fundus and stitched at the upper end of the incision to the peritoneum and fascia. The lower end of the incision was brought together with through and through sutures of silk worm gut. A drainage tube was inserted into the gallbladder and seven small pieces of gauze were packed beneath it, next the perforation.

The child's condition seemed to be about as good at the end as at the beginning of the operation. The urine contained bile for a few days but soon became normal. The patient had no unfavorable symptoms and was progressing splendidly until January 8, twelve days after the operation, when she was taken with severe pain in the abdomen, about one o'clock in the morning. Her temperature was 97°, pulse 96. The dressings were changed and the wound found in a healthy condition. Enemata were given but only a very small amount of mucus and a few small pieces of fecal matter were obtained. At eight o'clock she took a dram of salts which was repeated in an hour and then she vomited. She was then given calomel, grain one-fourth, every two hours. At 8:40 her pulse was 120 and intermittent. There was some fecal vomiting. Her stomach was washed at 11:50. The wound was again dressed and the abdomen found slightly distended. A diagnosis of obstruction from adhesions was made. An anesthetic was again administered, beginning with a few drops of chloroform, followed by one and a half ounces of ether. The incision was made just to the left of the original opening and passed close to the old stitch marks which had been infected by the discharge from the gallbladder. The ileum was found adherent to the wound for some distance and was greatly distended above this point but comparatively flat and normal looking below. The adhesions were carefully separated and a portion of the bowel, denuded of peritoneum, was stitched over with fine silk. She had very little pain after the operation. At 4 P. M. her pulse was 170 and she continued to vomit material with a fecal odor. The pulse came down to 110, from 9 to 11 P. M. At 2 P. M., the next day, the pulse was 106 and she expelled an enema with considerable gas. The pulse remained about the same until seven o'clock in the evening when it reached 118 and then gradually increased in rapidity till she died, at 2:40 A. M., January 10, thirty-eight hours after her second operation and just two weeks after the first one. A post-mortem examination showed a general peritonitis. Except for the accidental obstruction from adhesions the operation would have been successful, although three or four competent surgeons had pronounced the case hopeless.

During twelve years in Seattle only three cases in my practice have died of typhoid fever. One death was from exhaustion due to hemorrhage and neglect, the wife, a morphia fiend, being the nurse. The second one was due to intestinal perforation, in a girl about fourteen years old. This I failed to diagnose early enough to give operative relief and it was the first and only case ever treated by me with the strictly Woodbridge treatment. The third was this little girl with the perforation of the gallbladder who died from peritonitis following operation for obstruction due to adhesions. In all my abdominal surgery only two patients have developed such obstruction of the bowels and these two occurred within thirty days of each other, this being one of them. The other was a man with appendicitis with abscess who developed an obstruction just twelve days after the operation. This patient was relieved by operation and recovered.

In regard to the causes of perforation in this case I have thought the podophyllin, which was given the day before, might have had some effect by increasing the amount of bile and consequently the pressure in the gallbladder.

John F. Erdmann, in the Annals of Surgery, June, 1903, reports a case of gallbladder perforation and refers to the literature on the subject, giving a total at that time of thirty-four cases. Twenty-seven of these were not operated upon and all died, two had incomplete operations and died, and five had complete operations with four recoveries and one death.

In regard to treatment, there is no doubt that the proper thing is immediate operation and it is likely that the delay of about fourteen hours, during which time the bile was irritating the intestines, was at least partially responsible for the adhensions which caused the obstruction and death of this patient. Early diagnosis and prompt operation will materially lower the present mortality from perforations in typhoid, whether of the intestine or gallbladder. Every patient with typhoid fever should be closely observed and any unusual symptoms carefully noted. Usually the diagnosis of perforation can be made with considerable certainty but it may be difficult to decide whether it is the intestine or gallbladder. The intestinal perforation is so much more common that in this particular case it was the only thing considered in the diagnosis. The location of the first pain noted and the previous history of unusual tenderness about the gallbladder would suggest its possibility. The most important point, however, is to diagnose perforation without specifically stating its location. The treatment in either case is immediate laparotomy.

Recently several articles have appeared on the subject of perforation in typhoid fever, notably those of Harte and Ashurst, in the January number of Annals of Surgery; G. E. Armstrong, Annals of Surgery, November 1902, and Dr. Elsberg, in the July number 1903, on the perforation of typhoid fever in children. As a general concensus of opinion the three most important symptoms are pain, rigidity and tenderness. Dr. Armstrong says, "The note of alarm is pain,—abdominal pain referred to the umbilical or hypogastric regions. A very common bedside note is to the effect that 'at midnight on a certain date the patient complained of the sudden onset of abdominal pain: an enema was given and followed by a stool, semisolid or watery, which gave great or complete relief. About four hours later the pain recurred, and the abdomen was then found to be tender on pressure at some point,—more frequently in the right hypochondrium,—and more or less rigidity with rounding up'." And then further he says, "The first associate symptom is tenderness; the second, rigidity; and the third, fixity in one spot." There are other symptoms of greater or less importance, any one of which may be of value in a given case. The leucocyte count seems to be somewhat variable and may give its information rather late, as in the case just reported; vomiting may or may not occur; the temperature may drop to below normal and then rise later, or it may increase so soon that by the time it is taken there is an elevation; there is at the same time likely to be an increase in the rate of the pulse and respiration: on account of stimulation of peristalsis there may be one or two loose evacuations of the bowels, or, from paralysis of peristalsis, obstinate constipation may result; the facial expression is pinched; there may be a disappearance of liver dulness, but this may also occur without perforation. In the average case of perforation a probable diagnosis is easily made soon after its occurrence, but if a patient is stupid or almost comatose with an already tympanitic abdomen, the diagnosis may be very difficult indeed, if not impossible. Under such circumstances rigidity is the most important symptom. Dr.

Armstrong also mentions pin-point perforation allowing a slight leakage as being very misleading in regard to diagnosis. In reference to this he says, "The great diagnostic feature here I have found to be persistence of a little pain and a little tenderness and a little rigidity with fluctuation in temperature and pulse."

The treatment of perforation of either gallbladder or bowel is immediate operation. We should not wait to be *sure* there is a perforation, but should operate in all cases where we *suspect* it and in case of a mistake in diagnosis little, if any, harm will be done our patient. Next in importance to early diagnosis and early operation is the advisability of operating upon every such patient, no difference how low his condition unless actually moribund. Shock or collapse following perforation should have no deterring effects, for it is certainly not good surgery to allow the peritoneal cavity to be filled with fecal matter or bile, as a treatment for this shock.

An operation of this kind should be done rapidly but with every care in regard to aseptic technic and completeness of detail in the operation. Of two deaths with incomplete operation referred to by Dr. Erdmann, one patient died nineteen hours after the operation which had been discontinued on account of collapse of the patient. Incomplete operation means almost as certain death as no operation and consequently should be a very rare occurrence. Dr. Erdmann removed the gallbladder in the case reported by him and as a rule this would probably be the better treatment, but with my patient her condition was so exceedingly serious at the beginning of the operation that I would in a similar case drain the gallbladder and leave it.

HUMANITY AND COMMON SENSE VERSUS IDEALISM IN VENEREAL PROPHYLAXIS.*

By G. S. PETERKIN, M. D.
Seattle, Wash.

The problem of venereal prophylaxis is not a simple but a complex one, presenting innumerable hygienic, sociologic, economic and moral questions, the solution of which is of vital importance to the well-being and evolutionary progress of the individual and nation.

Among races, sects and individuals an apparent irreconcilable variance now exists, not only concerning the extent and degree of the detrimental influences of immorality and its sequelae, venereal diseases, but especially concerning the mode of prophylaxis to be adopted. This is mainly due to the fact that the ethical question of morals is interwoven with every phase of the question of preventation of venereal diseases and that humanity but indistinctly recognizes that the law of nature, governing man's moral acts, demands that every man, because endowed with a mind that possesses individual volition and reason, must make his own morality. Hence it is essential that he be rendered capable of making it for himself. To do so, he must be enlightened, guided, advised, and placed in a position to judge so that theory may determine a practice that suits him.

The existence of immorality is due primarily to the existence of the sexual instinct. The theories of prophylaxis to be proposed, to be adaptable and useful, must be governed by a knowledge of the workings and purposes of the law of sexual instinct. To propose and present theories, moral and hygienic, is the only practical and rational method of venereal prophylaxis that can be established, at this period of evolution.

Since minds are brought into agreement by furnishing them with universal and necessary principles, while principles of moral action, like truth, cannot be imposed by brute force, but must be proposed by some, accepted by others, and thus become common through free adhesion of minds.

This preamble is essential as an introduction, for in it are stated the facts and principles that demonstrate the potentiality by which man's actions are governed when dealing with this subject.

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*Read before the Washington State Medical Association, Seattle, Wash., July 12, 13 and 14, 1904.

To simplify and limit the discussion, I shall state in definite terms the essential and basic principles upon which the system of venereal prophylaxis to be outlined will be constructed.

And I will try to reason logically and govern my reason, not by principles of wisdom, the valuation of which depends upon their beauty and elevation of thought, but by principles drawn from the scientific study and observation of man and society as they now are, and history shows them to have existed.

THE ESSENTIAL AND BASIC PRINCIPLES.

1. Venereal diseases are detrimental to the evolving of every individual.

2. The object of venereal prophylaxis is to aid all humanity in its evolutionary advancement.

3. Prostitution and venereal viruses cause venereal diseases.

4. Prostitution has existed always and will continue to do so indefinitely.

5. Every human being possesses the absolute right to make his own morality and, as a woman is a human being, she has a right to prostitute herself as well as man.

6. Man does not possess the power to create, control or destroy eternal organic laws of nature, by means of statutory or constitutional laws of his own creation.

7. Prostitution is dependent for its existence upon an eternal, organic law of nature, essential to life, the sexual instinct that is given to man for two reasons, to perpetuate the species and to rivet the tie between husband and wife, not only by offspring, but by mutual endearment.

8. Venereal viruses are potent instruments in the law of evolution, created by nature as a protective force to defend the law of sexual instinct from transgressions or perversions of its principles. They act by aiding the fit to survive, by destroying or rendering sterile the unfit and the ignorant.

9. The sexual instinct every human being possesses, even in the purest; it is of necessity an alloy, made up like ourselves of body and mind, the grosser so influxed with the more ethereal that the one finds its most passionate expression in the fruition of the other.

It has been stated that organic laws of nature can not be controlled by constitutional and statutory laws of man, and prostitution and veneral viruses, as entitities, are parts of an eternal organic law, the sexual instinct. Therefore, prostitution and veneral viruses cannot be controled by constitutional or statutory laws of man. In other words, the idealisms, total suppression or reglementation of prostitution by the enactment of constitutional and statutory laws, are practical impossibilities.

Proceeding and analysing the law of sexual instinct for the purpose of obtaining a working hypothesis, the following may be deduced and accepted as true, that the law of sexual instinct is an immutable and eternal physiologic law, and veneral diseases are but pathologic results, due to transgression of its principles by man in the making of his own morality, which he must make for himself. The remedy is now self-evident; it lies in teaching the individual to understand the workings of the law of sexual instinct, that he may comprehend its character and the practical advantage of complying with its demands.

In as much as immorality is the voluntary right of an individual, and sexual intercourse is animated by an immutable and powerful physiologic law, and education must be selected as the only means of controlling immorality, the power of education to control, will depend upon the extent that true facts and principles can be produced that will demonstrate to the individual mind,

First, Immorality is contrary to the law of self preservation, that is, causes chronic ill health, immediate or remote, and death;

Second, Immorality does not bring but diminishes an individual's happiness, and limits his ability to mentally and physically enjoy the great benefits and pleasures to be obtained from normal sexual intercourse;

Third, Immorality acts contrary to the laws of evolutionary advancement, necessitating degredation of mind and body.

Educational methods which aim to prove these truths may be aided by sociologic, economic, and legislative means, as, "Labor laws that provide that the minimum rate of wages for female employees over sixteen years of age shall not be less than a sum sufficient to keep such a person in food and clothing, according to the prevailing social condition to which such employee is reasonably entitled; divisions of the sexes in work shops; working women's and men's compulsory sick-benefit, accident, invalid, and old age insurance societies and mutual aid and loan associations for industrial workers, to tide them over in time of non-employment; asylums, where friendless working women could find accommodations at nominal rates or, where in temporary embarrassment or out of work, they could be accommodated gratuitously in lieu of some work exacted from them; better housing facilities, shorter working hours, extension of the eight-hour law as constituting a day's work. In addition, industrial schools, cooking and servants schools, etc., should be established."

Such means will illustrate at present the proper uses and limitations of constitutional and statutory laws, when dealing with this subject of prostitution and venereal diseases.

Returning to the object of this paper, the consideration of the means of educating the individual, the following is suggested: The stating of scientific facts in a systematic, concise yet acceptable manner, so that men and women, knowing them, will see the necessity of protecting themselves and in so doing will limit the spread of venereal diseases. These facts may be arranged in pamphlet form, under the following headings:

PAMPHLET I, FACTS FOR ALL MEN.

First: Continence, if mental and physical, is not incompatible with health and can be maintained.

Second: Nocturnal emmissions (wet dreams) are normal, and in moral men do not indicate disease, though the contrary may be the case in an immoral man who has suffered from an attack of clap or gonorrhea.

Third: Immorality degrades man mentally and physically and renders him incapable of attaining the greatest possible benefits and pleasure from the very object whence he seeks to obtain them, sexual intercourse. Facts and illustrations essential to prove the truth of statement three would necessitate the consideration of the part that the mind plays in sexual intercourse and the subject of mental hygiene. Time is limited; hence it will suffice to state that. to be immoral, man must allow the physical instead of the mental instinct to control his being: in so doing he must lie, be unjust, cowardly and cruel to womankind, and in his endeavors to obviate the depressing effects of such actions he contracts habits that will be detrimental to the enjoyment of sexual intercourse to the fullest extent.

Fourth. Youths and maidens should be educated not only in the anatomy and physiology of the generative organs but also in sexual hygiene. and as to the ultimate purposes and workings of the law of sexual instinct and the beneficial results and happiness to be attained from its proper indulgence.

The full significance of the third and fourth statement can best be demonstrated by the following illustration:

Characters: (a) A maiden, pure minded and innocent, in the sense that she is ignorant not only as to the anatomy and physiology of her sexual organs, but also as to their purpose. Maintained in this ignorance for the sake of purity, her sexual instinct remains undeveloped, or what is more probable, it is prevented by impossible or idealistic misconceptions. (b) A youth who has had sexual intercourse and has had his sexual instinct developed; his textbooks smutty stories, and his teachers ignorant companions, rues and prostitutes. The two become engaged. He reforms in anticipation of marriage. The wedding night he enjoys the excitement, drinks wine. She does not. He has been content with the anticipation of physical pleasure; she only with the anticipation of the mental phase and emotion of matrimony. That marriage night what happens? She sees man physically as he is and he, inflamed with excitement, drink and abstinence, does what? Has sexual intercourse with her once, more often several times without the slightest thought of the effects of such actions or the endeavor to properly awaken the sexual instinct within her. She, a woman of sentiment, is expected to do the impossible, to develop in a night an instinct that for the greater part is emotional, in her nominally slow, and that she has been taught to be ashamed of. The immediate results—disgust or passive submission; the future results, unhappiness or divorce; the proper results, mutual endearment and the perpetuation of the species.

. Can thinking men see such marriages, and they are in the majority, and still countenance the prudery that causes the incalculable mutual unhappiness, licensed prostitution, that is, divorce, and makes prostitutes out of married women and married men supporters of prostitutes.

Fifth: Early marriages should be advocated.

Sixth: The medical profession and clergy should refute the old saw that, "He who sows his wild oats when young, will make a good husband."

Seventh: In other words, there should be demonstrations by competent and scientific men, of the fact that there is such a thing as "sexual honor" and that its advantages are individual as well as national.

PAMPHLET II, FACTS FOR SOME YOUNG MEN.

First: Syphilis and gonorrhea cause death. Eighty per cent. of all deaths from diseases of the generative organs of all women are due to gonorrhea or clap; forty five per cent. of these are due to marital infection.

Second: Syphilis takes two years to cure and during this time the hygienic rules to be carried out practically demand isolation. Acute gonorrhea or clap requires two weeks to three months to cure: chronic, an indefinite period, with the ever present fact that irreparable damage often results to the urinary and genital organs and the whole body from its presence.

Third: The stoppage of the visable discharge is positively no proof of cure of gonorrhea.

Fourth: The certificates, so conspiciously posted in the rooms of prostitutes and reading somewhat after this fashion, "We have made a careful examination of said Mary Smith, and find her free from veneral disease.". Signed, John Doe, M. D., are no proofs that she is not infectious. Practical experience and the light of scientific knowledge has demonstrated that such certificates have no value except to lend a false sense of security.

Fifth: A prostitute in a first class house is capable of holding this position on an average of four to six years. This signifies what? That, in compliance with the law of supply and demand, a virtuous girl must be obtained thus frequently to fill the vacancy. Can there be any greater argument for preserving the health of those who are already prostitutes?

Sixth: A prostitute in a house, in order to pay her board and necessary expenses, must have intercourse on an average of four times a day. To a man having intercourse, this is a pleasant thought, especially when the character of those who have gone before are brought to mind—diseased men, rounders, pimps, and drunks, who can hardly take care of themselves, much less keep clean.

Seventh: Again, and this fact demonstrates a kind of being that patronizes houses of assignation, a prostitute to hold her position must commit buccal coitus. And men under such conditions make love to, caress and kiss such women, and then go home to a wife or sweetheart. *To teach what prostitution is, is to teach morality.*

In pamphlet III statistics may be given as to the dangers and monetary losses caused by venereal diseases. Many of you have already received a pamphlet of this character.

PAMPHLET IV. PERSONAL PROPHYLAXIS AGAINST VENERAL DISEASES FOR MEN DURING SEXUAL INDULGENCE.

Eighty per cent. of all men in large cities have or have had gonorrhea. Every prostitute must be looked upon as infected with gonorrhea and statistics have shown that almost every fourth disseminates syphilis. Seventy per cent. of all gonorrheal infections are traceable to prostitution. (From the report of the committee on prophylaxis of venereal diseases of American Medical Association, May 9th, 1903.)

Means of prophylaxis in order of efficiency.

First: Continence is the positive preventive.

Second: Washing of genitals with soap and water once daily for 365 days in the year, especially the glands penis after drawing the foreskin (prepuce) well back.

Third: The condom, sufficiently strong as to remain unbroken, preferably of fish-skin.

Fourth: Abstain from intoxicants.

Fifth: If condoms are objected to, be circumcised or at least have the frenum cut.

Sixth: Have the woman wash with boracic solution before intercourse. This affords you protection from her own gonococci and those that are apt to have been left by the previous recipient of her favors.

Seventh: Have intercourse with urine in bladder. Immediately after ejaculation pass urine as forcibly as possible and, while so doing, suddenly stop the flow by placing the finger over the mouth of penis (meatus). Repeat this act two or three times during urination. This mechanically cleanses the urethra.

Eighth: After this the external genitals and hands should be washed in a one to two thousand bichloride solution, in order to prevent infection from the syphilitic virus and the conveying of the gonococci to the eyes, and it is best to wash the hands again in plain hot water.

Ninth: After these precautions, if the probability of the infection be considered great, it is best to consult a competent physician. If this can not be done, the following plan may be carried out: Use urethral syringe with the blunt glass tip preferred, capacity two drams, and a solution of argyrol, 20 per cent. in glycerine. Solution should be in a large mouthed bottle that will admit syringe. Before using injection, always urinate. If solution is poured out in a glass in order to fill syringe, see that the glass has been cleansed in scalding hot water. Syringe should always be scalded before and after using. The mouth of the penis (meatus) should be washed off well before injecting fluid. These precautions are necessary to prevent bacteria, gonococci or other kinds, on the outside, from being forced into the urethra and exciting or causing complications of a disease that you are trying to prevent.

Method of injecting fluid: Grasp penis tightly with thumb and little finger of left hand so as to completely close the urethra two inches from meatus; place the index finger of the same hand above and behind the head and the middle finger below: then steady the organ. Having filled syringe with fluid, expell all air, take it in the right hand, press nozzle tightly against meatus, inject slowly, gradually forcing the solution in until it completely distends that portion of the canal that is between the mouth and compressing fingers. Retain ten minutes. Repeat treatment three times in twenty-four hours. If there be pain on urination and discharge appear, immediately consult a reputable physician.

P. S. All these means, except continence, are injurious to health of mind and body but are less dangerous than venereal diseases.

PAMPHLET V. PERSONAL PROPHYLAXIS AGAINST VENERAL DISEASES FOR WOMEN DURING INTERCOURSE.

What is said will apply mainly to public prostitutes. The measures advocated recognize the existence of the fact that prostitution is undertaken as a means of livelihood or profit; therefore it is a business and must be conducted upon a business basis in order to be as profitable as possible to the individual and the least dangerous to the community. The commodities that she barters are personal appearance, animation, character and health. The two former depend mainly upon the latter for their value. Health, therefor, is a prostitute's greatest asset. The longer a woman maintains these products in the maximum condition, the greater will be her profits and the less her expenditures. In other words, a woman will be of greater monetary value to herself and less dangerous to the community, the better and the longer she maintains her health.

The principal factors appertaining to this occupation, outside of the lack of the general hygienic and sanitary condition that act detrimental to health, are veneral disease, drink, abortions and her social position.

In advocating venereal prophylaxis, all immoral women must be divided into two classes: (a) Women who have venereal diseases and do not know it. This is possible and true, especially in the majority of cases of chronic gonorrhea. For though infectious, the woman may have no localized or characteristic pain, or other subjective or objective symptoms of the disease beyond the habitual leucorrhea or white of women. And even this may be absent. (b) Women who have venereal diseases, especially chronic gonorrhea, and know it and yet carry on sexual intercourse.

This latter class, not few in number, are only complying with the law of self preservation, for it often demands this act of them as it demands that they, suspecting that a man has a contagious discharge, must take the chances of contracting disease in order to live.

Steps essential to cause personal prophylaxis to be adopted by these women are:

First: Teach them that the science of medicine exists for the purpose of preventing and curing disease, no matter its causes or character, and also to aid suffering no matter in whom; that, as its followers, we are ever, as its tenets dictate we should be, physicians and counsellors not persecutors and prosecutors.

Second: If the houses of assignation or segregation are tolerated, have the municipal authorities force the owners of such buildings to comply with the established laws of sanitation, especially as to size and ventilation of rooms, sewerage, bathing facilities, etc.

Third: Demonstrate why, according to the laws of nature, venereal diseases are dangerous to them, to their health and to society.

Fourth: Instruct them as to the clinical symptoms of venereal diseases, so that they may recognize them.

Fifth: Instruct them as to the means of preventing venereal diseases, and of controlling infection when they see it present in their patrons, or it has occured in themselves.

Pamphlets that contain these ideas in an elaborate form, their titles and methods of distribution, can not be considered here. Yet, it is necessary to briefly outline the means of controlling venereal diseases that lie within the power of these women to comply with, and which they themselves will enforce, as it is to their personal advantage. These are such as,

(a) Instruction as to general health, bathing, regular attention to toilet, drinking of sufficient amount of water, etc.

(b) The proper method of taking a douche, the temperature of the water, etc.

(c) The worthlessness of a macroscopic examination, and the value of the microscopic to themselves.

(d) Teaching the use of the speculum and tampon to one of the inmates of an assignation house, so that tampons may be used and frequently changed, and thus infection prevented. especially when intercourse is indulged in during the existence of a chronic infection, or when the menstrual period is present.

(e) The advisability of using an antiseptic as boracic acid instead of bichloride. The latter hardens and dries the vaginal mucous membrane, and thus increase the likelihood of minute lacerations to both the male and female, and as a result, the more ready innoculation of syphilis and chancroids.

(f) The hardening and drying of the vagina, which of necessity occurs from frequent douching, should be offset by the using of a lubricant during coitus. And this lubricant should be soluble in water, such as lubrin. Vaseline, even carbolized, is not advisable, for if this be used and bacteria are deposited in the vagina, they can not be washed out but are covered by the vaseline, and husbanded to do future damage to the woman, or to be rubbed into the meatus of the next victim.

(g) In washing external genitals they should be taught to rub away from the meatus and thus not infect the bladder.

(h) Glass urinals should be used in the bed-rooms instead of the usual vessels. Thus the presence of shreds, etc. in the urine will indicate to the woman the necessity of taking extra precautions.

These and many other instructions along similar lines could be given, and are not only common sense, but are in the bounds of duty.

To sum up, I would state that the object of this paper (it cannot do justice to the subject and many vital points are omitted)is to demonstrate that the best and most logical method of venereal prophylaxis at this stage of evolution is to be found in the education of the individual; that the educator must realize that every man must and will make his own morality; that the educator's line of argument, to be efficient, must deal with universal and necessary principles and be based upon actual conditions, not idealisms; that, from a stand point of morality, even in a small community, there are many men in various degrees of moral evolution; that they evolve by degrees; that different arguments appeal to different degrees of evolution; that to appeal to all classes and any individual, one must possess a good knowledge of every side of the subject to be dealt with and the principles that govern its action; and that the pamphlets here proposed are but a means to this end, in a convenient form for distribution by the busy physician as his discretion dictates.

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CLINICAL REPORT.

A CASE OF INTUSSUSCEPTION OF MECKEL'S DIVERTICULUM.

By E. Janson, M. D.
SEATTLE, WASH.

Last October I was called to attend Mr. H. J., who had just been brought in from the country to Seattle General Hospital. On investigation I found the patient had been suffering from an acute intestinal obstruction for the previous five days. Fecal vomiting had been constant for three days.

Examination showed the patient to be in partial shock, temperature subnormal, pulse rapid and of low tension, skin cool and calmy, abdomen tympanitic, but owing to external tenderness, palpation was unsatisfactory. Under these circumstances an operation was not deemed advisable. Four ice bags were applied to the abodmen. Gastric lavage of a 10 per cent boracic acid solution, with oz. 2 of spts. chloroform, was ordered every 3 hours. Absolutely nothing was allowed by mouth. Nutritive enemas of panapeptone, oz. 2, with oz. 3 of saline sol. were given every 3 hours; strych. sulph. by hypodermic and heat to the extremities completed the treatment. To our great surprise the patient gradually improved. At the end of 5 days his fecal vomiting had ceased and in a week he had a natural bowel movement. In 5 weeks from date of admission he left the hospital, to all appearances a well man.

I heard nothing of him until June 1, when he was again admitted, with another attack, but of less severity. The same treatment as previously was followed out, with gratifying result. He informed me, however, that he had never been entirely well since the first attack. The least indiscretion in his diet, or neglect to keep his bowels regular, would give rise to pain and a bloating of the whole abdomen which, after a while, would subside with a gurgling noise, a clear history of chronic intestinal obstruction. On leaving for home, I advised an operation in the near future.

In accordance with my advice, on June 24 he came down to have an operation performed, having felt badly ever since leaving the hospital. His general condition was not of the best, being greatly emaciated and run down. On June 25, with the assistance of Drs. Eagleson and McLaughlin, I operated. On opening the abdomen in the median line, there was an escape of considerable ascitic fluid. The peritoneum was greatly thickened, especially toward the fundus of the bladder. A large mass presented itself which, at first glance, had the appearance of a cancerous tumor. On closer investigation, however, it was found to consist of coils of small intestines, matted together and surrounded by large masses of lymph. In breaking up adhesions and carefully separating the intestines, we suddenly tore through one of the coils, where the seat of obstruction was found. In front of the obstruction the intestine was very much distended, having a pouch-like appearance. At the seat of obstruction the intestine seemed, at first sight, to be entirely occluded. After a dili-

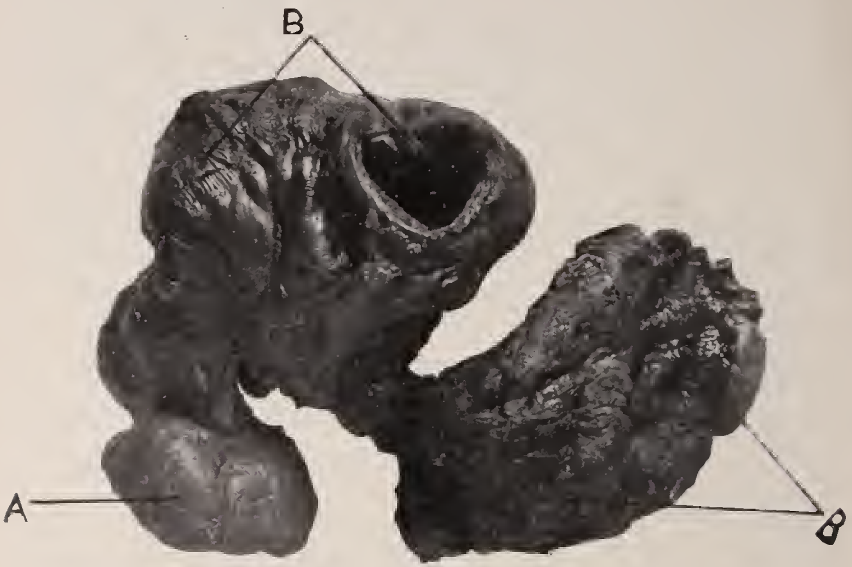

Fig. 1, Anterior view.

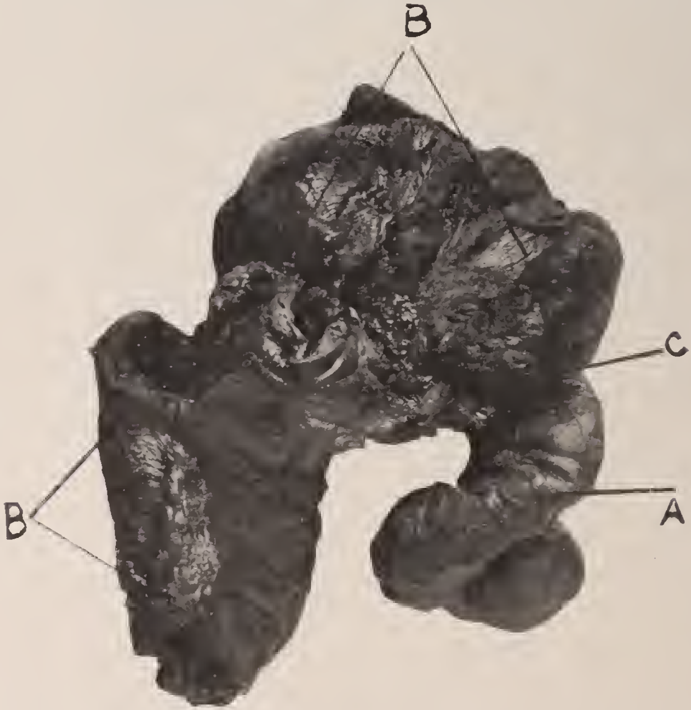

Fig. 2, Posterior view. A, Meckel's deverticulum. B, excised intestine. C, match in opening of intestine.

gent search we found to one side an opening large enough to admit the closed end of a pair of artery forceps. About 8 to 10 inches of intestine was resected and an end-to-end anastomosis made with a large-size Murphy button. The walls of the intestine being very much thickened, we had some difficulty in pursing the suture and forming a good approximation. As a safeguard a row of interrupted Lembert sutures was put in around the seat of anastomosis. The peritoneal cavity was filled with saline solution, causing the intestines to float, thus preventing adhesions from reforming. The abdomen was closed in layers, and the patient put to bed in excellent condition. In 12 hours, however, delayed shock appeared and he sank rapidly, dying 18 hours after operation.

On examining the specimen, the obstruction was found to have been caused by an invagination of a Meckel's diverticulum, which was doubled upon itself in the distal part of the resected bowel. The diverticulum sprang from the lateral aspect of the intestine, close to the mesentery. It measured 8 inches in length and 3 inches in circumference, and ended in a hard, club-like extremity. It had a small mesentery of its own. The two accompanying photographs give an idea of the appearance of the specimen, although they have been taken two months after removal, the specimen having been in a solution of alcohol and glycerine, thus causing considerable shrinkage. Fig. 1 shows the anterior aspect of the diverticulum and also gives a fair idea of the pouch-like, distended appearance of the intestine, anterior to the obstruction. Fig. 2 shows the posterior aspect of the diverticulum. A little to the left of the diverticulum I have introduced a match, to show where the opening was which formed the continuation of the intestinal lumen.

For months the patient had managed to live in comparative comfort, with all his intestinal contents having to pass through this small opening, a fit illustration of how nature will adapt itself to the most desperate of conditions. I held an autopsy on the patient, and found nothing to account for his death except surgical shock. Union was perfect at the seat of the anastomosis, with no sign of leakage. Adhesions had not reformed, and the intestines had a healthy appearance.

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THE CANADIAN MEDICAL ASSOCIATION.

This meeting in Vancouver, August 23-26, was the first ever held by the Association on the Pacific Coast, and the trip was a revelation to many who had never made it before. The prosperous and stirring young city of Vancouver made an excellent impression upon the visitors and the medical men of the city deserve great credit for the royal way in which they entertained their guests. Everything possible was done for their comfort and welfare during their stay.

The addresses and papers presented to the Association were of high order and every one felt fully repaid for his attendance at the meeting. The able and scholarly address on Diseases of the Pancreas, by Mr. Mayo Robson, of London, England, was a rare treat. While the attendance was not large, there being about two hundred and fifty members and guests registered, it was excellent considering the long distance from the large eastern centers of population. One noticeable feature was the large number of guests from the adjoining states of the U. S. There were nearly forty present from Washington and Oregon, and since medical men recognize no dividing lines, these visitors were received with the same cordiality as their medical brethren from Eastern Canada.

Though the visitors thought Vancouver had almost outdone herself in the way of social entertainment, the two days spent in Victoria proved that the capitol city of the Province was not one whit behind her younger sister on the mainland, and every one returned home delighted with British Columbia and her representatives of the medical profession.

OREGON STATE MEDICAL ASSOCIATION.

The Thirty-first annual meeting, which held its sessions in Portland, August 30 and 31, was a record breaker from every point of view. The attendance was much larger than ever before, the first morning session opening on time with more than 150 physicians present. In this Association there is a House of Delegates which transacts all business, and consequently the sessions are given over entirely to the scientific program, which was especially well chosen, containing, besides many leading men of the Northwest, such names as Charles Mayo of Rochester, Minn.; D. H. Niles and S. C. Baldwin, of Salt Lake City; Drs. Sherman, of Chicago; Huntington, Abrams and Rixford, of San Francisco.

The social features were well cared for. During the first evening a reception was given to the physicians and their wives at the beautiful Mt. Tabor home of the President, Dr. W. T. Williamson. The meeting was closed on the second evening with a smoker at Elk's Hall. A notable improvement in the social program was the marked attention given to the visiting ladies. They were visited by the wives of the local physicians and, beside many invitations to luncheons and dinners, were invited with the men on the first evening, and the next day were given automobile rides about the city, with a theatre party in the evening. This should always be a prominent part of the social program of any State meeting, for many physicians take with them their wives who, without social entertainment, have nothing to do but sit about their rooms in the hotels waiting for their husbands who are fully occupied, both scientifically and socially.

These meetings are held primarily for the scientific program and they are of great benefit to us all from that point of view, but it it not true that the good fellowship and friendly relations of the different men, established on such occasions, are of still more value in the elevation of the medical profession? The enthusiasm exhibited at the Oregon State meeting augurs well for the American Medical Association meeting at Portland next year. Our Portland brothers deserve a great deal of credit for their energy and ambition in securing this meeting, and every physician of the Northwest should make it his particular business to assist in contributing to its success.

SOME STATISTICS OF MEDICAL SCHOOLS AND PHYSICIANS.

The careful study of some of the medical directories, together with a little arithmetical calculation, may be made to yield interesting results. We discover that there are 169 active medical schools in the United States, although the deceased far outnumber the living. The states most favored in this respect are Illinois with 17, Missouri with 14, Tennessee with 12 and Maryland with 8. The ratio of medical schools to population is, however, higher in Maryland than in any other state, averaging one school to approximately each 150,000 inhabitants. Even Oklahoma may boast a medical school, but the following states and territories are luckily exempt: Washington, Mississippi, Florida, Delaware, Idaho, Indian Territory, Montana, New Jersey, Nevada, the Dakotas, New Mexico, Wyoming, Utah, West Virginia, Rhode Island, Alaska and Hawaii. There is a medical school in Manila.

The fees required in medical schools present the greatest variations. The one in which both the fee and the course are the longest is that in San Francisco—The West Coast Medical College, in which the annual fee is $250 and the course five years. There are very many medical schools asking only an annual tuition of about $50, and the New Orleans University Medical College (colored) demands but $40. But what will be thought of the medical department of the University of the State of Missouri which offers tuition free to medical students! We feel truly guilty to have unearthed this fearful discovery and we pray that it may be quickly buried in the limbo of medical journals. When the State of Illinois supports enough medical schools to amply provide the whole United States with medical pabulum it seems inhuman to offer medical instruction gratis.

According to a map, to be found in the eighth volume of the Reference Handbook of medical sciences, under "Physicians", displaying the ratio of physicians to population. in 1898 there were five states—California, Iowa, Indiana, Vermont and Ohio—which contained over 20 physicians to each 10,000 inhabitants. We calculate that in these states there are medical schools in the proportion of about 1 to 346,275 inhabitants, while in the four states and territories which held the fewest number of physicians in 1902

—that is 8 to 10 per 10,000 population—namely the two Carolinas, New Mexico and North Dakota, there is a ratio of but on medical school to nearly one million inhabitants. Our own state of Washington averages about 15 physicians to each 10,000 inhabitants and is below the middle in a list of states, according to the ratio of physicians, in which California stands at the head with 26.1, and South Carolina at the foot with 8.1 physicians to 10,000 population. Indeed California, among countries, and San Francisco, among cities, (with 31.5 doctors to each 10,000 inhabitants) leads the whole world in its plethora of medical men.

California almost equals Maryland in her superabundance of medical schools and it is no doubt partly to this fact that she owes her richness in medical men and it would seem as if she might well sacrifice the five tenths of a medical man in each ten thousand population without harm. According to the latest list, Indian Territory and Oklahoma must be added to the category of states (or territories) containing more than 20 physicians to the 10,000 population, while Iowa has now but 18.4 doctors to the same number of inhabitants. The tremendous growth of Oklahoma accounts for the inrush of physicians and Seattle would probably rival San Francisco in her surfeit of medical men were we not free from medical schools and were not the public protected by our rigid state medical examinations for licenses enabling physicians to practice within her borders. According to the 1904 city directory, Seattle contains 172,205 inhabitants and in the medical directory, under Seattle, may be found 267 names of physicians which gives a ratio of some 15.7 physicians to each 10,000 population.

The following statistics showing the ratio of physicians to each 10,000 inhabitants may be of interest for comparison. Countries: (approximately) Germany, 5; Austria, 4; Italy and Switzerland, 6; France, 4; Spain, 7; England, 6; Sweeden and Russia, 2.7; United States, 16. Cities: Paris, 9.7; Berlin, 14.1; Vienna, 13; New York, 17.1; Chicago, 20.5; Philadelphia, 21.8; St. Louis, 26.3; Boston, 26.8; Baltimore, 23, and San Francisco, 31.5. We do not, of course, pretend to enter into the causes of medical density of population, which are various, nor do we contend that the absurd and direful number of medical schools is even the chief cause, but we do affirm that it is one of the more important causes of the present medical plethora in the United States.

MEDICAL NOTES.

The July Meeting of the Washington Examining Board.—This meeting was held at Spokane. Hereafter the places of meeting will be reversed, that occurring during the hot weather of summer being held in Western Washington and the January session in Spokane. This will bring the next meeting at the latter city. The largest class on record appeared, numbering 102, of whom 17 failed to pass.

The Board decided to add the subjects of toxicology, bacteriology and pathology to the future examinations. Dr. Stuht was appointed to draw up a suitable combination of these subjects. The consideration of the subject of reciprocity was dropped so far as overtures from this Board are concerned. Dr. C. W. Sharples, Burke Block, Seattle, was elected Secretary.

The following is the list of the successful applicants:

G. G. Agerton, St. Louis, Mo.
W. T. Akey, Spokane.
J. N. Alley, Lapwai, Idaho.
Wm. Armann, Spokane.
A. S. Austin, Aberdeen.
H. R. Bankerd, Springdale.
Geo. G. Belden, Spokane.
E. A. Bingham, Puyallup.
E. H. Bradley, Seattle.
S. D. Briggs, Tacoma.
Adolph Bronson, Seattle.
J. H. Brower, Spokane.
T. C. Campbell, Hot Springs.
C. M. Chambliss, Spokane.
F. H. Collins, Goldendale.
G. W. Crawhal, Spokane.
F. M. Crosby, Tekoa.
I. J. Cross, Burton.
Joseph Dean, Detroit, Mich.
H. C. Dyer, Cle Elum.
H. L. Ewing, Philadelphia, Pa.
G. G. Fouser, Joliet, Ill.
J. H. Fitz, Garfield.
R. S. Forsyth, Gladstone, Mich.
F. M. Gage, Spokane.
R. S. Garnett, Tacoma, Seattle.
E. E. Grant, Seattle.
John Gilbert, Pomeroy.
H. M. Greene, La Crosse.
W. S. Griswold, Seattle.
J. C. Gunby, Seattle.
L. G. Halland, Johnson.
J. H. Hamilton, Nelson, B. C.
T. J. Kieffer, Seattle.
F. J. Lemon, North Yakima.
Ludwig Lima, Everett.
D. Livingstone, Seattle.
J. S. McBride, Ritzville.
H. H. McCarthy, Spokane.
A. L. McClanahan, Seattle.
D. McIntyre, DeSmet, Idaho.
Rush McNair, North Yakima.
F. W. Maier, Wilbur.
A. A. Matthews, Spokane.
E. O. Miller, Everett.
J. W. Mitchell, Linden.
R. I. Newell, Spokane.
O. P. Overton, Sheridan, Ore.
I. J. Pond, Minneapolis, Minn.
C. M. Post, Alfred, N. Y.
T. H. Potter, Seattle.
H. Power, Spearfish, S. D.
C. O. Reed, Bellingham.
H. L. Reese, Kelso.
F. A. Rice, Doe Bay.
P. E. Riley, Ellensburg.
E. B. R. Rogers, Seattle.
J. F. Schfcik, Hutchinson, Minn.
H. E. Schlegel, Spokane.
J. F. Schmershall, Chicago, Ill.
F. E. Schocht, Seattle.
E. W. Shead, Seattle.
O. M. Slate, Garfield.
C. L. Smith, Spokane.
J. S. Smith, Bellingham.
A. D. Snyder, Miles.

M. W. Harvison, Spokane.
W. A. Hibbs, Sunnyside.
D. A. Hewit, Spokane.
A. E. Hillis, Rosalia.
C. L. Hoeffler, Spokane.
E. L. Ingersoll. Spokane.
W. M. Karshmer, Puyallup.
R. G. Kellner, Hamilton.
W. R. M. Kellogg, Seattle.
I. U. Temple, Clarkston.
F. R. Underwood, Seattle.
T. Uyematsu, Port Blakely.
A. E. Walker, Duluth, Minn.
I. A. Weichbrod, Seattle
W. E. Welz, Detroit, Mich.
N. N. Wiger, Seattle.
C. B. Wood, Seattle.
J. W. Welch, N. Westminister, B.C.

American Medical Editors' Association.—The thirty-fifth annual annual meeting was held at Atlantic City, in June. It was one of the most successful in its history, as indicated by the addition to its membership and the interesting papers presented.

The following resolutions were passed relative to the use of patent nostrums:

Whereas, The public is, and long has been, suffering from the use of nostrums, and from the misuses of medicines, and,

Whereas, The medical profession and press have endeavored by every means in their power to instruct the laity upon the subject, and

Whereas, Some journalists either do not understand the true situation, or find it to their pecuniary gain to favor the use of nostrums and pander to the greed of their manufacturers at the expense of the health or even the lives of their dupes among the people, and,

Whereas, The eminent editor of the "Ladies' Home Journal," Mr. Edward Bok, in an able and vigorous editorial on page eighteen of the May number of that journal, laid the truth of the matter before his readers, thus aiding in the work of warning and educating and conserving the health and welfare of the public, be it

Resolved, That the American Medical Editors' Association approves and commends Mr. Bok for the intelligent, honest, fearless and well-grounded position he has taken, which has been thoroughly appreciated by us and by the medical profession generally.

Resolved, That a copy of these resolutions be spread upon the Minutes of this meeting, be transmitted to Mr. Bok, and be published in the medical journals throughout the country.

Dr. E. C. Dudley Before the Pierce County Medical Society.— On Sunday, September 4, the Pierce County Medical Society had as its guest Dr. Dudley, of Chicago. Before a large and appreciative audience, in the new Masonic Hall, he delivered a masterly lecture, beautifully illustrated by lantern slides, on surgical operations and pathologic conditions. It was doubly interesting because he so clearly brought out the technic of his own operations, especially those relating to uterine prolapse. Through his kindness in entering into every detail and his suavity of manner Dr. Dudley made a life long impression upon all who had the pleasure of hearing him. Beside many from Tacoma and the nearby towns, the King County Society was represented by Drs. Heg, Read, Moore, and Dawson.

Washington Physicians at the Portland Meeting.—The following were present from Washington: Drs. Wilson, Yocum, Bean, Hicks, E. M. Brown. F. H. Hill, of Tacoma; Eagleson, Willis, Peterkin, Nadeau of Seattle; W. Johnston, of Colfax; G. D. Wilson, of Pullman; Bell, of Kelso; Chalmers, of Vancouver; Simms, of Kalama.

Death of Dr. Becker.—Dr. A. R. Becker, for several years a resident of Seattle, died at the residence of his son in Victoria, September 2. A more extended notice of his life wil be presented next month.

TO OUR READERS AND CONTRIBUTORS.

All material for publication must be received by the twentieth day of the month preceding a given issue. Articles will be illustrated by half-tones or etchings when accompanied by photographs or drawings for the same. Reprints of contributed articles can be obtained at the cost of publication, from the Metropolitan Press, publishers of the Journal. A limited number of additional copies of the Journal will be supplied to contributors, if a request is made for them.

TO ADVERTISERS.

We wish to call attention to the fact that *Northwest Medicine* has no department for reading notices, publishers' notes, etc., and that the literary and advertising pages are entirely distinct.

REPORTS OF SOCIETY MEETINGS.

CANADIAN MEDICAL ASSOCIATION.

The Association met in O'Brien Hall, Vancouver, B. C., August 23d, at 10 a. m. After the reading of minutes, the introduction of prominent guests, and some general business, Hon. Mayor of Vancouver, Dr. W. J. McGuigan, one of the pioneer physicians of the Northwest, welcomed the members of the Association and gave them the freedom of the city.

The Address of Welcome to the Province of British Columbia was given by Dr. J. C. Davie, of Victoria.

The Address in Medicine was delivered by Dr. R. E. McKechnie, of Vancouver. This was a very able paper, dealing with the early practice of medicine in the Northwest and experiences with the native "Medicine Man." It was listened to with much interest, and a vote of thanks was tendered him by the Association.

The Business Aspect of the Medical Profession, by Dr. J. E. Hanna, of Ottawa, was read by title.

Afternoon Session.

The chairman of the Committee of Arrangements, Dr. W. D. Brydone-Jack, of Vancouver, published the announcements of the various receptions and entertainments for the members and visitors.

Patent Medicine, was read by Dr. C. J. Fagan, of Victoria. This gave rise to a great deal of discussion as to the best means of checking this growing evil. It was finally resolved that Dr. Fagan, and such gentlemen as he wishes to assist with him, should be appointed a committee to draft a resolution on the question of patent medicines.

The following telegram was read by the President:

New York, Aug. 23, 1904.

S. J. Tunstall, M.D.

Thanks for kind invitation. I greatly regret cannot attend meeting. The press here, medical and lay, refers triumphantly to Osler's appointment as Regius Professor of Medicine at Oxford. King Edward approved it. Osler has accepted for next year. God bless dear old Canada, McGill and Osler. Yours faithfully,

Wolfield Nelson.

New Color Test Apparatus, by Mr. Mansfield, Fleet Surgeon, H. M. S. Grafton, was read by Dr. Campbell, of Vancouver.

Several papers were read by title, owing to the absence of the authors.

At 9 p. m., the citizens of Vancouver gave a "Conversazione" to the members of the Association and their guests at the Hotel Vancouver, which was a brilliant social function, and was attended by over five hundred.

WEDNESDAY, AUG. 24.

Morning Session.

There was an election of new members and some general business was transacted.

The Address in Surgery was delivered by Mr. Mayo Robson, of London, England. He took for his subject his later investigations on Diseases of the Pancreas. It was profusely illustrated by lantern slides. A vote of thanks was tendered Mr. Robson for his most excellent and comprehensive address.

Hernia of the Bladder, Complicating Inginial Hernia, was read by Dr. F. J. Shepherd, of Montreal. It was discussed by Dr. McDonald. of Toronto; Dr. Meek, of London: Dr. Secord, of Brantford, and Dr. Eagleson, of Seattle.

Movable Kidney, was read by Dr. K. A. J. McKenzie, of Portland, Ore. It was discussed by Dr. Coffey, of Portland, and Dr. Eccles, of London, Ont.

Papilloma of the Larnyx.—An interesting case of this condition was reported by Dr. Robert H. Craig, of Montreal. The subject was discussed by Drs. Hackett and Irvine, of Montreal.

Hypertrophy of the Breasts.—An interesting case of this disorder was reported by Dr. S. R. Jenkins, of Charlottetown, P. E. I.

AFTERNOON SESSION.

The Nominating Committee was elected and some general business transacted.

Therapeutic Hints from Bacteriology.—A paper on this subject was read by Dr.. D. Cruickshanks, of Windsor, Ont.

A Further Study of Neuroses as Seen in Orthopedic Practice.—This paper was read by Dr. B. E. McKenzie, of Toronto, Ont.

Mr. Mayo Robson operated, at the Vancouved City Hospital, on an interesting case of occlusion of the common bile duct, making an anastomosis between the gallbladder and the colon by means of a Murphy button.

Afternoon tea was served to the visitors and their wives at Pendor Hall, at 4 p. m.

The Annual Address of the President was delivered by Dr. S. J. Tunstall, which was very entertaining and elicited a vote of thanks from the Society.

The Address in Gynecology was delivered by Dr. E. C. Dudley, of Chicago. It was a very able presentation and was profusely illustrated by lantern slides. He was given a vote of thanks by the Association. At the close of the session Dr. G. W. Grant described the new city hospital and illustrated the plans by lantern slides.

THURSDAY, AUG. 25.

MORNING SESSION.

Mr. Mayo Robson performed a Gastro-enterostorny on a case of stricture of the pylorus resulting from an old ulceration.

The usual general business was transacted.

Tubercular Peritonitis.—This paper was read by Dr. C. H. Mayo, of Rochester, Minn., and was listened to with much interest, being subsequently discussed by several members.

Meckel's Diverticulum, with Report of Cases, was read by Dr. H. Howitt, of Guelph, Ont.

The Lorenz Reposition of Congenital Dislocation of Hip.—Dr. C. W. Wilson, of Montreal, reported his results after a year of this treatment, illustrated by photographs.

Several papers were read by title owing to lack of time for their presentation.

During the afternoon the members and their guests were taken on an excursion to New Westminster and for a ride on the Fraser River. It was most enjoyable.

At 9 p. m. the members and guests were given a dinner at the Hotel Vancouver, which was most elaborate, and so entertaining that the party did not break until early morning.

FRIDAY, AUG. 26.

Morning Session.

After the reports of various committees, officers were elected for the ensuing year. Dr. John Stewart, Halifax, was chosen President. Vice-Presidents and other officers were elected from different sections. Halifax, N. S., was selected for the meeting of 1905.

In the afternoon the members and their families took the Steamer Princess Victoria, for Victoria, B. C., where they arrived at 6 p. m. At 8 p. m. they were taken on an excursion up the Gorge in launches and were entertained on the trip by an open air concert by the Arion Club.

SATURDAY, AUG. 27.

The forenoon was spent in carriage and tallyho drives about the city. In the afternoon the members were taken on a steamer excursion to Esquimalt, Williams' Head quarantine station, and a trip along the Coast, facing the Pacific ocean and straits.

The day closed with an elegant reception given at the Parliament Buildings by the Government officials.

OREGON STATE MEDICAL ASSOCIATION

Thirty-first Annual Meeting, at Portland, Ore., Aug. 30 and 31, 1904.

The meeting was called to order by the President, W. T Williamson. Judge Williams, Mayor of Portland, was introduced and gave the address of welcome, which was humorous and entertaining.

Notes of a Case of Cerebral Hemorrhage.—This was the first number on the scientific program, read by W. J. May, of Baker City. He detailed a case of a man, 62 years old, who came under his care 78 days after having been thrown from a horse. During that time he did not have sufficient symptoms to consult a physician. Dr. May found the pupils normal, the right side of the face paralyzed, functions of the 9th, 10th and 11th cranial nerves impaired, tongue protruding to one side. Appetite and general condition was good. He was at this time delirious, no history could be obtained, and no relatives were present from whom consent could be obtained for operation. He grew worse, and in three or four weeks went into profound coma so that there was no corneal reflex; he could not swallow, and had Cheyne-Stokes respiration. At this time they decided to operate, and on opening the meninges on the left side, fluid, which proved to be from a degenerated clot extending from the frontal to the occipital region, gushed forth as though it were under heavy pressure. The next day he was conscious, rational, and there was only a trace of paralysis, which later disappeared and he was discharged from the hospital in two weeks, apparently cured. After considerable dissipation he returned two months after his discharge from the hospital with pus running from the right ear, and died about a week later with an abscess on the right side of the brain. He called attention to the following points of interest about the case: First, the size of the clot; second, the fact that there was a period of 78 days after injury with no symptoms; third, normal condition returned so soon after operation; fourth, the effect of alcohol on his paralysis. He also called attention to the fact that no case is so bad as to be entirely hopeless.

Dr. Josephi, in discussion, wanted to know whether there was tonic spasm of one or both arms, whether there was word blindness and deafness, and whether there was mind blindness and deafness. He also urged that in such a case as that operation is justifiable and even imperative without the consent of friends.

Dr. May, in closing, said that a tonic spasm was in the right arm and hand and that there was both word and mind blindness and still insisted that operation should not be performed without consent of patient or friends.

Clinical Observations on Blood Pressure and the Diagnosis of Abdominal Arteriosclerosis.—This paper was written by Albert Abrams, of San Francisco, but in his absence was read by James F. Bell, of Portland.

The paper discussed in an able manner the life subject of arteriosclerosis. The author made a special point of determining the question of high pressure and force of the heart, doing away with the vaso motor factor by giving amyl nitrite.

Dr. Hutchinson said that much is unknown about arteriosclerosis. We are just learning that we do not have kidney and lung diseases primarily, but that they are a part of the general arteriosclerosis, and that this is particularly true with disease of the kndneys, which is really vasomotor disease. He called attention to the fact that we have in the past paid too much attention to the valves of the heart, and have forgotten that the heart was only an enlarged part of the great vascular system. He believes that the high blood pressure is due to toxins, and it is due to the fact that potassium iodide eliminates toxins that it has been of such great value in medicine. He also mentioned thyroid extract as another important eliminant.

Dr. Rixford, of San Francisco, reported a case of a man aged 70 who, after pneumonia, developed abscesses throughout the body from which a pure culture of the pneumoccus could be obtained, and soon after recovery from this developed arteriosclerosis in a very marked degree and died from gangrene in the toe.

Dr. Bell, in closing the discussion, said that he believed nitro-glycerine, on account of being less fugaceous in its action, would be superior to amyl nitrite.

On the General Usefulness and Adaptability of the Stimpson Splint. This was reas by Geo. F. Wilson, of Portland. The author showed how simple it was to apply a Stimpson splint, which consisted of a plaster of Paris bandage with the folds placed in a longitudinal manner in case of fracture of the leg, whether simple or compound.

Dr. Yocum, of Tacoma, opened the discussion, and said that he believed this was a good splint in many cases, but that it would not be as good around the leg which would produce even and firmer pressure in those cases where there is swelling.

Dr. Huntington, of San Francisco, called attention to the added responsibility on the part of the surgeon since the use of the X-ray. He felt that no splint could be depended upon for adjustment of the fragments but that, in addition to the splint, it making little difference what splint is used, extension could not be added. In compound fracture he believed there would be danger in the application of the Stimson splint from infection. In his practice he allowed a compound fracture to rest on a pillow for the first five days while he treated the wound and after that treated the fracture.

Dr. Sherman, of San Francisco, also called attention to the danger of sepsis, but thought the splint mechanically sufficient. He also mentioned the Bavarian splint.

Dr. Pilkington, of Astoria, advised the use of vaseline before the application of the splint to prevent the hair sticking.

Dr. Wilson, in closing, urged the necessity of setting the fracture at once, even if compound, and called attention to the fact that he kept the wound covered with antiseptic gauze, while manipulating the fracture. He also said that he did not use wire in fractures because it tended to cause necrosis.

AFTERNOON SESSION.

Cancer of the Large Bowel.—This was the leading paper of the session, read by Charles H. Mayo, of Rochester, Minn. It comprised a very full discussion of the subject, as would be expected from such an author. He gave many valuable practical points in regard to treatment, one being especially novel and useful—that of colostomy—being done by bringing the two ends of the bowel into the wound and snapping the forceps with one prong down either end of the bowel.

Diagnosis of Inflammatory Lesion of the Upper Half of the Abdomen.—This was presented by D. H. Niles, of Salt Lake City. The author handled his subject in his usual clear and concise manner, and especially emphasized the fact that symptoms of disease in those regions always had some corresponding pathologic lesion as an abscess.

Dr. W. W. Bird, of Salem, led the discussion.

Posterior Gastroenterostomy for Non-Malignant Conditions of the Stomach.—This paper was read by C. W. Huntington, of San Francisco. He described the operation in a clear and full manner and detailed twelve cases in his own practice.

J. B. Eagleson, of Seattle, led the discussion, which was continued by C. H. Mayo, with instructive facts concerning the operation.

A Discussion of Some of the Newer Aids in Surgical Diagnosis was read by Park Weed Willis, of Seattle.

This was limited to the subjects of blood, blood pressure and the X-ray. Routine hemoglobin estimation prior to the administration of anesthetics was urged, as was also the question of coagulability in all cases of disturbance of the gall passages. The importance of leucocytosis in inflammatory disturbances, and especially in reference to obscure abdominal ailments was dwelt upon at some length. Differential count was urged as important in all conditions. Blood pressure as estimated by a modification of the Riva-Rocci instrument was discussed with reference to increase of intra-cranial pressure. Mention was made of the importance of the X-ray at the present time as a diagnostic agent, and greater triumphs were prognosticated for the future, especially with reference to renal calculus and gallstones.

Discussion was led by Harry M. Sherman, of San Francisco, who agreed with all that was said in reference to coagulability, leucocytosis and X-ray. He questioned the reliability of hemoglobin estimations and on the question of blood pressure, having had considerable experience, he was less hopeful than the author of the paper as to the results obtained.

WEDNESDAY, AUG. 31.

Morning Session.

A Surgical Clinic was held at St. Vincent's Hospital at 8 a. m. T. W. Huntington, of San Francisco, operated on a case of chronic stenosis of the pyloris, doing a gastro-enterostomy; and also on a case of inguinal hernia in a male.

J. B. Eagleson, of Seattle, operated on a case of subacute appendicitis.

Milk as a Diet for Children.—This was read by G. S. Hicks, of Tacoma, and was discussed by Woods Hutchinson, of Portland.

Report of Cases of Tubercular Peritonitis.—This was presented by K. A. J. Mackenzie, of Portland. It was discussed by Drs. Smith, of Portland; Bean, of Tacoma; Coffey, of Portland; Eagleson, of Seattle; Niles, of Salt Lake, and Cauthorn, of Portland.

K. A. J. MacKenzie, who was appointed by the American Medical Association as chairman of Committee on Arrangements for the reception of the Association in Portland next year, named Wm. Jones, A. C. Smith, H. W. Coe, G. F. Wilson, A. J. Giesy and Ernest F. Tucker as the other members of the committee.

J. B. Eagleson, of Seattle, and Harry Sherman, of San Francisco, pledged their respective states to assist in every way possible in making the Portland meeting of the A. M. A. a most successful one.

Afternoon Session.

Dr. Watkins, of San Francisco, exhibited a German machine for aiding in the treatment of deformities of the spine.

Congenital Dislocation of the Hip.—Harry Sherman, of San Francisco, read this paper, in which he advised the discontinuance of the Lorenz bloodless operation and advocated the open method of dealing with the deformity, by which the head of the femur could be most accurately replaced. According to his observations the cases that had been operated on by the Lorenz method were almost all failures.

This was discussed by Drs. Baldwin, of Salt Lake City, and Watkins, of San Francisco.

Dr. E. C. Dudley, of Chicago, gave an address on gynecological subjects, illustrated by lantern slides.

Some Painful Conditions of the Feet, was read by C. Baldwin, of Salt Lake City, and was discussed by Dr. Watkins, of San Francisco, and others.

Fractures of the Elbow Joint with Gunstock Deformity.—This paper was read by Emmet Rixford, of San Francisco, in which he held that the deformity was not caused by an elevation of the internal condyle of the humerus by an inward rotation of the lower end of the fractured bone with the forearm.

Several papers were not read on account of lack of time.

BOOK REVIEWS.

Edited by
Kenelm Winslow, M. D.

Dudley's Gynecology. New (4th) Edition. A Treatise on the Principles and Practice of Gynecolocy. By E. C. Dudley, A. M., M. D., Professor of Gynecology in the Northwestern University Medical School, Chicago. New (4th) edition. Revised and enlarged. Octavo, 771 pages, with 401 illustrations, of which 50 are in colors, and 18 full-page colored plates. Cloth, $5.00, net; leather, $6.00, net; half morocca, $6.50, net. Lea Brothers & Co., Phila. and New York, 1904.

In Dudley's Gynecology we have the most complete of recent text books on the subject which we have seen in a single volume. Both the medical and surgical sides of the topic receive thorough consideration. In no work is the wonderful advance in medical books, in the way of illustrations explanatory of the text, more noteworthy than in the present treatise. Every detail of operations from the minor to major are portrayed, as for instance, thirty-two drawings describe perineal lacerations and the steps of perineorrhaphy, while twelve are devoted to the steps of hysteromyomectomy and the same number to abdominal hysterectomy. The most minute technical details of preparation, operative technic and after-treatment are given so that the book possesses peculiar value to the general practitioner. The chapter on diagnosis is particularly to be commended, also that on local treatment.

The author is not especially favorable to local treatment of the endometrium. In one place he says, "A very large proportion of the women who were formerly made the subject of extensive intrauterine treatment should be treated by medical or surgical means or should be relegated to the field of internal medicine." In another place the writer remarks that, "A reproach will be lifted from the medical profession when the indiscriminate use of topical treatment has been relegated to the dark ages of gynecology." And with this the reader will no doubt heartily agree. WINSLOW.

Serums, Vaccines and Toxins in Treatment and Diagnosis. By Wm. Cecil Bosanquet, M. A., M. D., F. R. C. P., Lond. 340 pp. 7⅝x5 infl $2.00. Chicago, W. T. Keener & Co.

This brochure is one of a series in preparation on Light and X-rays; Radiant Heat; Organo-Therapy; Minor Surgery and Open-Air Treatment of Consumption. If they are all as compact and practical as is the present volume concerning subjects, many of which are most difficult to present in a lucid form, the result will be most desirable. In the book under discussion will be found chapters upon, Recovery and Immunity, the Preparation and Administration of Serums and Vaccines, and the detailed use of Serums and Toxins in Diagnosis of Disease. Special chapters are given to the use of Serum, Toxin and

Anti-toxin treatment of Diphtheria, Tetanus, Snake-Bite, Small Pox and Vaccinia, Hydrophobia, Plague, Enteric Fever, Cholera, Tuberculosis, Malignant Tumors, Streptococcus infections, etc. Bosanquet goes into all the minute details in the use of animal products which are so essential to their judicious use and discusses impartially their possible dangers. He is not in the least arbitrary and gives the varied opinions of authorities all over the world concerning the dosage, worth, etc., of the measures under discussion but generally manages to present to the reader a clear summary and conservative estimate of the subject which is admirably done, considering the difficulties which hamper one who would treat plainly and decisively of this novel and but recently developed branch of medical science. A quotation in regard to tuberculin as a diagnostic agent may show the tenor of the book. "Taking all the evidence at present available, the conclusion appears to be that there is no more danger in administering a diagnostic dose of tuberculin than in giving an anesthetic for similar purposes." * * * "In no case should we adopt either means if it is possible to make a diagnosis otherwise." * * * "In the majority of cases it is probably preferable to wait, but if the matter is one of urgency, we should not hesitate to make use of the drug."

Taking the book all in all it is a remarkably clear, concise and readable presentation of a most important matter and one which is almost unknown to the majority of medical men and for that very reason should especially commend itself to them.

WINSLOW.

The Student's Handbook of Surgical Operations. By Sir Frederick Treves. New edition revised by the author and Jonathan Hutchinson, Jr. 121 illustrations, 486 pp. 7½x5⅛ in.; cloth, $2.50. W. T. Keener & Co., Chicago.

The present work includes the technic of the most essential and commonly performed operations and is an abridgement of the author's Manual of Operative Surgery. Some of the minor operations are not touched upon. The author's description of appendectomy is very good but he styled McBurney's incision as "clumsy and rather cramped and only sufficing for uncomplicated cases." In discussing the choice of union in intestinal anastomosis or in union of the stomach and bowels, Treves says, "The chief point to be considered is whether Murphy's button or a double row of sutures is to be employed," and remarks that, "Most surgeons have, however, after trial of the button, returned to the use of the direct suture." He prefers a continuous suture of the mucus membrane, covered in by a row of interrupted Lembert sutures for the muscularis and peritoneum. The O'Connell method of intestinal suture receives no mention. There is a beautiful simplicity of style and action and a solid conservatism which ignores or brushes aside many of the unnecessary modern frills in technic for those which time has sanctified so that one can not help admiring, even if not wholly in sympathy with such a state of mind. As a whole the manual is a most excellent practical guide for the student.

WINSLOW.

REPORT OF CONTAGIOUS DISEASES.

To the Washington State Board of Health for July, 1904.

Counties.	Smallpox		Scarlet Fever		Diphtheria		Typhoid Fever	
	Cases	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*
Adams	0	0	2	1	2	0	0	0
Chehalis	0	0	0	0	2	0	0	0
Chelan	0	3	0	0	0	0	0	0
Douglas	0	0	0	0	2	1	0	0
King	1	0	5	1	8	1	1	0
Kitsap	0	0	1	0	1	0	0	0
Klickitat	0	0	0	0	0	0	1	0
Lewis	0	0	0	0	0	0	3	0
Lincoln	0	0	0	0	4	0	2	0
Pierce	0	0	0	0	2	0	2	0
Skagit	0	0	2	0	0	0	0	0
Skamania	0	0	0	0	2	0	1	0
Snohomish	2	0	0	0	0	0	6	0
Spokane	1	0	1	0	1	0	0	0
Thurston	0	0	0	0	3	1	1	1
Whitman	0	0	0	0	1	0	7	0
Yakima	0	0	1	0	0	0	2	0
Bellingham (city)	0	0	0	0	0	0	2	0
Seattle (city(	4	0	14	0	13	3	6	1
Spokane (city)	5	0	5	0	13	3	1	0
Tacoma (city)	2	0	1	0	6	0	2	0
Total	15	0	35	2	60	9	36	2
Total, July, 1903	56	4	82	6	21	3	9	4
Total, 1904	264	6	792	36	680	97	271	63
Total same period 1903	711	8	645	18	146	18		

ELMER E. HEG, Secretary.

MEDICAL SOCIETIES.

Name. Meetings Held.

Washington State Medical Association.................1905—Tacoma
President, J. R. Yocum, M. D.; Secretary, A. H. Coe, M. D.

Chehalis County Society ....Second Tuesday—Aberdeen
President, D. A. Schumacher, M. D.; Secretary, J. W. Scamell, M. D.

Chelan County Medical Society................................
President, W. M. McCoy, M. D.; Secretary, H. A. Saunders, M. D.

King County Society ....First and Third Monday—Seattle
President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

Lewis County Society ....First Monday
President, J. T. Coleman, M. D.; Secretary, Charles Harden, M. D.

Pacific County Society ....
.............Third Monday of Jan., April, July, Oct.—South Bend
President, G. W. Overmeyer, M. D.; Secretary, Mary W. Gunwell, M. D.

Pierce County Society.............First and Third Tuesday—Tacoma
President, C. Quevli, M. D., Secretary, A. de Y. Green, M. D.

Skagit County Society ....
President, A. C. Lewis, M. D.; Secretary, R. J. Cassel, M. D.

Snohomish County Society...................First Tuesday—Everett
President, C. A. Mead, M. D.; Secretary, James Chisholm, M. D.

Spokane County Society...................First Thursday—Spokane
President, G. S. Armstrong, M. D.; Secretary, Geo. A. Gray, M. D.

Walla Walla County Society.........Second Wednesday—Walla Walla
President, N. G. Blalock, M. D.; Secretary, Y. C. Blalock, M. D.

Whatcom County Society..................Second Monday—Whatcom
President, D. E. Biggs, M. D.; Secretary, W. N. Hunt, M. D.

Whitman County Socity.........Third Monday of Jan., Apr., July, Oct.
President, W. N. Divine, M. D.; Secretary, R. J. Skaife.

Yakima County Society..............First Tuesday—North Yakima
President, David Rosser, M. D.; Secretary, Carver, M. D.

Oregon State Medical Association ....1905—Portland
President, Geo. F. Wilson, M. D.; Secretary, L. H. Hamilton, M. D.

City and County Medical Society of Portland...First Wed.—Portland
President, R. L. Gillespie, M. D.; Secretary, A. D. Mackenzie, M. D.

Multnomah County Medical Society..........First Tuesday—Portland
President, A. Tilzer, M. D.; Secretary, L. Victoria Hampton, M. D.

Montana State Medical Association 1905
President, B. C. Brooke, M. D.; Secretary, Grace W. Cahoon, M. D.

Silver Bow Medical Society....Second and Fourth Wednesdays—Butte
President, T. J. Murray, M. D.; Secretary, Grace W. Cahoon, M. D.

Idaho State Medical Association............October 6 and 7—Lewiston
President, J. L. Conant, Jr.; Secretary, E. E. Maxey, M. D.

North Idaho District Medical Society..............June 9—Lewiston
President, C. L. Gritman, M. D.; Secretary, C. D. Parsons, M. D.

South Idaho District Medical Society.........Jan. 5, 1905—Pocatello
President, H. A. Castle, M. D.; Secretary, E. W. Kleinman, M. D.

British Columbia Medical Association...............1904—Vancouver
President, A. P. Procter, M. D.; Secretary, W. D. Brydone-Jack, M. D.

Vancouver Medical Society ....Vancouver
President, W. D. Brydone-Jack, M. D.; Secretary, J. S. Conklin, M. D.

Corrections and additions to this list are requested from societies reached by this journal.

NORTHWEST MEDICINE

October, 1904.

PRESIDENT'S ADDRESS.*

By Simon J. Tunstall, M. D.

Vancouver, B. C.

I feel that my first duty tonight is to offer you my very hearty thanks for the honor you have conferred upon me in electing me President of the Association for the present year. When I recall the names of those who have preceded me in this chair I can only ask your indulgence for the deficiencies you may find in me, of which I am very conscious, and express the hope that under my presidency, the interest of the Association may in nowise suffer nor its honor be in any way tarnished.

The present occasion is no ordinary one. In the appointment of a President from among the members of the Association whose home and work lie in this far distant portion of the Dominion, and in our meeting here today at the doorway of the West, a new departure has been made.

I am far too modest to suppose for an instant that any particular merit of mine has induced the Association to make this departure; rather I conceive it to be due to a general recognition of the claims and standing of the western members as a whole, and of the growing importance of this fair western Province.

I should be performing my duties but poorly did I not seize this early opportunity to thank you on behalf of my western confreres, and on behalf of the people of this Province in general, and of this city in particular, for the compliment you have paid us in selecting this Province and this city as the place of meeting for this year, and I feel I am only expressing their wishes in tendering you a hearty western welcome to our midst, and their hopes that your brief stay among us will be both pleasant and profitable to you all.

To many of you, probably most of you, the rapid progress and general development of this young Province will come as a surprise. It does to most of our visitors from the older parts of the Dominion who know how recent has been the settlement of the West. And certainly looking round one, it does seem scarcely realisable that the site of this rapidly expanding city, of which its citizens are so justly proud, and this very spot on which this building stands, surrounded by so many comforts and refinements of modern life, was less than two decades ago a wild and almost impenetrable virgin forest, the haunts of the bear, the deer, and the primitive savage. It is less than a score of years by two that the incorporation of this city took place, and yet today it will compare favorably with many cities in the older Provinces twice and thrice its age. From the medical standpoint it is reaching after a high ideal.

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*Read before the Canadian Medical Association, Vancouver, B. C., August 23—26, 1904.

The incomparable water supply which is brought in closed steel conduits from the bosom of the mountains to the North of us, the sewerage system with its septic tanks that deliver their effluent into tidal waters, the paved streets with their array of cleaners, the cement sidewalks which are now throughout the city rapidly replacing the earlier and cruder planking, the public and private hospitals, the General Hospital which is now being built and which when finished will be the peer of any hospital of its size, all make it clear that we are endeavoring to keep abreast of the times as well in sanitary as in other matters.

It is no idle boast then, if I say that in the West events move rapidly. Time is no sluggard here, and we see history fashioning itself before our eyes. The whole of this great Province was in undisputed possession of savage aboriginies a half century ago. The closing years of the first half of the nineteenth century saw the first real settlement made on Vancouver Island at a place called Camosum in the native tongue, now Victoria, the capital of the Province.

A few years later, in 1858, an Act was passed in the Home Parliament to provide for the government of this new colony, thereafter to be known as British Columbia. From this date the real settlement of the Province begins. The discovery of gold in the Fraser and Cariboo soon made these districts as famous and as widely known as Sacramento or Ballarat, and a great inrush of population was the result. But a very few years later the conception of that colossal and momentous undertaking, the building of the Canadian Pacific Railway, began to shape itself in men's minds and was finally carried out. You are all doubtless familiar with the history of that great undertaking and know the almost insuperable difficulties its earlier promoters had to contend with, and how in the end, in spite of political, natural, and every other obstacle and hindrance, they successfully carried through the scheme and made possible the union of British Columbia and the great North West with the rest of Canada, and gave us as a result that splendid heritage, that united land which stretches from ocean to ocean, from the rising of the sun to the going down thereof—a land of which all her sons and daughters are so proud—our beloved Canada.

It is gratifying to our profession to know that it has been ably and honorably represented among those history makers in the persons of Drs. Helmcken and Tolmie who were the first medical men to settle in the colony, about the middle of the last century. Both took prominent part in the earlier events of the Province. The former still remains among us; the latter has gone to his rest. Prior to their advent the native medicine man had it all his own way.

There is a significance, not without interest to my mind, in the fact that this Association, representing as it does today in its various members the highest medical knowledge of this enlightened period of the world's history, should meet here in this new country where Shamanism, or the cult of the savage "Medicine Man," so recently prevailed and does to some extent still prevail. The old and the new order of things are thus brought into suggestive contrast and juxtaposition, and we are led naturally to reflect upon the stages and steps we have passed since the days when all medical knowledge was comprised in the superstitions and rude practices of our savage prototypes, and in spite of our some time failures and our lack of knowledge, still in certain directions the reflection on the whole is a pleasant and gratifying one both to ourselves and humanity at large. It certainly would not be the least interesting of subjects were I to attempt on this occasion a general survey of the march and progress of Medical Science from the days and practices of the primitive Medicine Man as we find him even in this Province, down to the time and discoveries of Lister, Pasteur, Virchow and their followers.

But it is not my intention to undertake such a task tonight, interesting and appropriate as it might under the circumstances be, although I cannot leave the subject without calling your attention briefly to a fact of which all of you may not be aware and which gives pertinence to my reference to the old time Shaman or Medicine Man. We are all familiar with hypnotism, but there are few of us perhaps aware that in the employment of hypnotism as a therapeutic agent we are returning to primitive methods, to the practice of our savage prototypes. Those who have made special study of the practices and customs of savage races inform us that the primitive doctor, or Medicine Man, was not that self-conscious fraud and humbug knowingly duping his credulous patients he is commonly thought to have been: but a person who had a real belief in his own powers and cures: and that those powers and cures were, when genuine, generally, if not always, attributable to hypnotism, especially to that phase of it known as suggestion. A state of hypnosis was induced in his patient by the monotonous droning of his medicine song and the noise of his rattle, and when in this condition his attempt to extract the spirit of the disease from the patient's body, and his statement that he had presently accomplished it, acted suggestively upon the imagination of the patient and effected his cure. "Extremes meet," and there is nothing new under the sun, we are told, and the school of Nancy, which is founded upon the suggestive phase of hypnotism is not a new practice but an unconscious return, or rather I should say it is an unconscious modification and extension of these primitive methods which were in vogue among our savages here up to a few years ago, and may be to this day for ought I know to the contrary.

But enough on this head. It is my intention rather to bespeak your consideration tonight of a point or two which I, in common with many members of the profession, have very much at heart, and which I deem of such importance as to merit our most careful consideration and endorsement.

I have reference in particular to,

I. The Canadian Medical Protective Association.

II. The Federal Health Bill.

III. The Dominion Medical Council.

IV. The Treatment of Inebriates.

With regard to the first, The Canadian Medical Protective Association, I would desire to urge upon members the strong claims this Association has upon the profession. I am among those who believe in the need of such an Association and that it may be made a valuable means of assisting and protecting members of our profession from wrongful actions-at-law, to which we are all of us at all times liable; actions brought by irresponsible persons for alleged malpractice, or by unscrupulous persons for the purpose of obtaining money under threats of injury to our professional character.

It is well known that a medical man's professional prospects depend to a very large extent, if not entirely, upon his professional reputation, and it is not difficult, therefore, for unprincipled persons to attempt to levy blackmail upon him by threatening to bring action against him for malpractice or professional incapacity, which action, though wholly groundless and undeserved, may have the most disastrous effects upon his career and pocket.

During the past two years the Association has fought out several such cases successfully and has amply demonstrated its usefulness and justified its existence. It is therefore a matter of wonderment to many of us that the Association has thus far received so little encouragement or support from the profession as a whole. Out of a possible 5,500, the total membership last year was only 252. This is altogether too small a number to make the aims and work of the Association effective, or sustain it in a solvent condition, and I welcome this opportunity to invite your earnest co-operation in enlarging its membership and strengthening the hands of the executive, and would to this end suggest that a special committee be struck during the convention for the purpose of considering how best to enlist the sympathies and support of our brethren who are not yet members. I cannot but think that a large increase in the membership must inevitably result if the aims of the Association be once rightly understood.

The objects of the Association are such as all can subscribe to. It is not intended to defend or assist in defending unworthy members. or those who are actually guilty of malpractice, or who have brought discredit upon the profession. It aims rather to assist the worthy, those of its members who are wrongfully charged and whose character and reputation are placed at stake; and also to deter irresponsible and unscrupulous persons from bringing action against members of the profession for the purpose of spiting or injuring them, or of exacting a bribe for their silence; and it is only by uniting ourselves together in such a way as this Association offers that we can hope to secure the support of our brethren and become immune to many attacks which would otherwise be made upon us.

I feel therefore that we have but to devise some plan of arousing the interest of our brethren in the matter to ensure their support and co-operation.

And now a word or two as to the Federal Health Bill. Thanks to the energetic efforts of the special committee appointed to attend to this matter, considerable progress has been made toward the attainment of our desires in this behalf. The interest and sympathy of the Ministers of the Crown has been secured, and the Minister of Agriculture, the Hon. Mr. Fisher, under whose department the matter more directly falls, has taken the matter up most courteously and is thoroughly alive to its urgency and need. For the information of those not familiar with this subject I would briefly say that the Association, at its meeting in Montreal in 1902, placed itself on record by resolution to the effect that it is expedient that a Department of Public Health be created by the Dominion Government and administered under the authority of one of the existing Ministers of the Crown, thus bringing all general questions relating to Sanitary Science and Public Health under one central authority to be known as the Public Health Department. There is no need for me to dwell upon the importance or desirability of this step; it must commend itself to every member of the profession.

Thus far the Government has not seen its way to grant the desired measure. The work is not yet accomplished and the need of pushing the matter still exists. I sincerely hope the meeting will not dissolve without first passing a strong resolution in favor of the measure and thus encourage and strengthen the hands of the committee who have this work in hand.

And now I desire to touch upon my third point, which I regard as of the highest importance. I refer here to the Dominion or Canada Medical Act which was assented to in the Federal House, in 1902. We are under a deep debt of gratitude to the members of the Special Committee, and especially to Dr. T. G. Roddick for his untiring efforts to get this measure placed upon the statutes of the country, and it is with great regret that I notice so much misapprehension as to the scope and powers of this Bill still exists in certain quarters. It has been thought that it would encroach upon the rights and privileges of the different Provincial Medical Boards and interfere with their autonomy, and I gladly hail this opportunity to say a few words which may help to remove this misapprehension. It was, and is, not in any way intended to interfere with existing provincial rights or intrench upon the prerogatives of Provincial Medical Boards. As an instance, in my own native Province, Quebec, our French speaking brethren will have the right of examination in their own language.

Provincial registration and Provincial Boards will still continue to exist and each Province will be at liberty to fix whatever standard it pleases for its own practitioners. They can, where they wish, continue as examining boards with power to grant Provincial Licenses, as they now do, and in any case in their hands will be left all matters relating to taxation and professional discipline.

The Bill is a purely permissive one, and though it has been placed upon the statutes of the Country, it will be necessary, before it can become operative, to have the consent and co-operation of all the Provincial Medical Boards. Each Provincial Board will have to seek a slight amendment to its present Medical Act. This is all that is now required to make this most desirable measure effective and I sincerely trust that this consent and co-operation will not be long wanting, for the aims and scope of this Act are such as should commend themselves to every member of the profession. Briefly, I would say that the main purpose of this Bill is to establish a Central Medical Council of Canada with power to examine candidates and grant licenses, the possession of which shall ensure to the holders thereof such a medical status as will enable them to practise not only in all parts of the Dominion but in the United Kingdom as well, or indeed in any portion of His Majesty's Empire; in short, to do away with those mortifying disabilities under which a medical man trained in Canada now labors and put him upon a footing of professional equality with his brethren in other parts of the Empire. This is assuredly a laudable and most desirable object, and one which, in my humble opinion, should call forth the best efforts of each one of us to bring about its accomplishment; and I sincerely trust that some concerted action will be taken in this matter before the meeting closes. It is the least, I think, we can do to show our appreciation of the strenuous efforts exerted in securing the passage of so important a measure.

This brings me to my fourth and last point—The Treatment of Inebriates. A conviction has been steadily growing in the minds of most medical men of late years that something should be done for the care and control of dipsomaniacs and inebriates, in the form of founding establishments combining the main features of an hospital and an Insane Asylum, where drunkards could be legally confined under medical authority and treated in a systematic and enlightened manner. The practice hitherto of treating them as criminals, subject to a fine or short period of confinement in the common prisons of the country, has been shown to be wholly unsatisfactory and often productive of the greatest evil to themselves and those who may be dependent upon them.

There can be no doubt, I think, that the care and treatment of those unfortunate members of society, is a question of the gravest and most vital importance and should command the interest and attention of medical men as a subject, which, coming well within their province, affects so seriously the general commonwealth.

A movement toward this end has already been taken in Ontario, and a Bill drafted, the principles of which have received the endorsement of the Toronto Medical Society and also of our own Association; but what we want is a Dominion Act affecting the whole country, and it would be the source of the greatest satisfaction to me if this meeting would take this question up seriously and nominate a Committee to draft a measure that could be submitted to the Federal authorities. This could be done either on the lines of the Ontario Bill or any others that might command themselves.

Speaking personally, I may say that I shall be only too glad to help in drafting such a measure and giving any other assistance in my power. For I am convinced that the adoption and carrying out of the provisions of a bill of this kind will do much to diminish the volume of sickness, pauperism, vice, and crime that now stains the annals of our country and restore to lives of usefulness and self-respect many of those poor unfortunate whom it is the design of such a measure to control and help.

Before closing my address I wish to express to our visiting brethren my appreciation of the kindly feeling and interest which have actuated them in taking part in the deliberations of our National Association and to help that their stay may be fruitful of pleasant reminiscences.

And now, gentlemen, I must thank you for your kind reception of me as your President this year, and for the patient and courteous hearing you have given to my remarks, and trust that the suggestions I have ventured to offere may meet with your approval and receive your support.

ORIGINAL CONTRIBUTIONS.

WHAT IS FEVER?*

By Woods Hutchinson, A. M., M. D.

PORTLAND, ORE.

I am here to ask the question, What is fever, not to answer it. It has been fermenting in my mind for some eighteen months past. We all know perfectly well what fever is, and what to take for it—generally the wrong thing—but when we come actually to define what is this curious rise of temperature, with its accompanying discomforts and weakness, and often consequent death, we find ourselves in the same situation that we are in a great many others—that our language is only a means of defining our ignorance. We know fever; we stick the thermometer under the tongue, we take the pulse, and say the individual has fever. The flush of the cheek, the glitter of the eye, the delirium of the mind, weakness, pain, etc., have imbedded themselves in the literature not merely of science, but of the race. It has been our impression and feeling that in dealing with fever we were treating a process which was in reality only an exaggeration of normal processes. It is precisely that question to which I would like to call your attention, whether we have not been treating as a foe one of our best friends, even such an every day friend as fever. Its danger seems to lie in one of two directions; one, such rapid burning that in a short time the body will burn itself out; and the other, that mere elevation of temperature for more than a certain length of time is injurious as such to the body. All the drugs which incumber the materia medica, as antipyretics, have been devised to prevent the body from burning itself up. That I regard as irrational. A few extra degrees of temperature are a mere nothing to a healthy body.

Is animal heat in any sense a vital necessity? We have had the impression it was. We have been taught that heat, 98.6°, is absolutely necessary for carrying on the vital process; that any departure several degrees below or above was a fraught with danger. I believe that the temperature is a result of the working, if not a waste product, of the body machine. If the body machine were working ideally there would be no friction to make temperature, and that part of energy which is turned into heat is wasted. The maintenance of a temperature of 98.6° is simply an expression of the amount of waste energy which we have to throw aside in the body, and which the mechanism of respiration is devised to enable us to get rid of without endangering the integrity of our own tissues. In other words, when we have an elevation of temperature, the elevation is the smallest thing that is detrimental in the situation, and all means directed to the cure of fever simply by lowering the temperature are really time wasted and energy misspent. My reasons for believing this and for presenting it to you would, I am afraid, take us farther afield than your patience would tolerate; it would carry us completely outside, not merely of the human species, but of the warm blooded animals—even to the plants. I will only make a very brief excursion.

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*Read before the Washington State Medical Association, Seattle, Wash., July 12, 13 and 14, 1904.

The question of temperature cannot be decided any more than any other question, simply from an inspection of one species. The man who knows only the human species does not know the human species. It is absolutely impossible to solve one of the simplest problems of human metabolism unless we are able to contrast it with not only one, or a dozen,but a hundred different forms. When we step outside of the human species we find that instead of 98.6° being the necessary, wellnigh sacred standard, a part of the plan of salvation, it is merely that degree of waste of energy in the organism which happens to coincide with the highest degree of efficiency in the human being. The dog and the pig have normal temperatures of 102° and 104°. On the other hand, the cat, the sheep and goat have temperatures of 102°, 104° and 105°. The rabbit has a temperature normally of 102°-106°. Birds have a temperature of 108° and 110°, the swallow reaching 118°. The temperature of the species is merely, so to speak, the working equation of the mechanism of that particular species. There is no necessary dependence of working efficiency upon a temperature of 98.6°. The range of perfect activities runs from 85° to 87° in Marsupials, up to 118° in the swallow.

In the cold blooded animals the bodily heat is from 6 to 10° above or below the temperature of the surrounding medium. To say that the animals are cold blooded is really inaccurate. They are simply changeable. The variations of their temperatures are no greater than those which we, as individuals, can undergo in health and disease. The cold blooded animal has a temperature of its own and keeps to it—usually 8 to 10° from its surroundings. Plants have a temperature of their own, but it is negative. It is from 3 to 10° below that of their surroundings and yet any of you who has been upon the mountain snow-line has seen little flowers pushing their way up through the snow-crust. A plant will live vigorously and actively at a temperature at which animal tissues would congeal; and if you were to take the temperature of that plant you would find it only 3° to 5° above or below its surroundings. Fungi, which grow upon the surface of the snow, are illustrations of the fact that life can exist practically without what is termed heat. The plant instead of making and wasting heat is absorbing it from its surroundings, and in process of synthesis and growth is storing that heat away in the form of structure. "Cool as a cucumber" is not merely a figure of speech—it is a fact. Its temperature is well below that of the surrounding air.

In the causation of temperature we reckon with three distinct processes. (1) Changing potential energy into energy of secretion and growth. If that is well done it will be without any heat whatever. (2) The process of new growth and building up of the tissues, attended by the absorption of heat instead of the giving out. (3) The familiar process of sucking in air and burning up the waste of our tissues, and blowing it out again as CO^2. Respiration would be superfluous if our machines were geared more accurately. The reason for this can be very well seen in the relation of a cold blooded animal to its oxygen intake. The temperature of the cold blooded animal is nearly that of the water in which he lives. The great majority of large bodies of water do not vary more than 10° to 15° in the course of a year. The range of temperature in cold blooded animals is relatively slight. The worm will have an average temperature of perhaps 62°. We have one of 98.6°, but the worm will carry out all our vital activities with the absoption of only about 1½ gm. of oxygen to every gram of his body weight, while the frog requires 2.5-3.5 gm., we 9.0-12 gm., the dog 12-15 gm. and the birds 25-35 gm. per gram of body weight per diem. In other words, he performs his vital activities almost solely on the energy which he takes out of his food, without wasting more than a mere trifle in friction and consequent heat. Economically considered he is a better labor-saving machine than we are.

You may consider this rather a far cry from fever, but I believe it will give us the key to the problem. We have long been in a quandary as regards fever. It is the common belief when fever sets in something has set a match to us. We have a sort of belief that our metabolism has been elevated to a fighting pitch and we are prepared to destroy microbes by that process. There are two difficulties in the way of this; if you feed an engine to a higher pressure of steam you get more work, you do not get it out of the human body in fever. The higher the temperature the more the body is incapacitated. Bile and gastric juice cease to be secreted, muscular activity sinks to the lowest level, the patient is absolutely paralyzed. A man with an attack of the grippe is as absolutely incapacitated as if struck by lightning—there is utter stoppage of metabolism.

The next difficulty is that when we came to studying gaseous interchange, we find that instead of the intake of oxygen being increased and the output of CO^2 in proportion, they are tne same as in health, and in a few hours or days sink below. The condition of oxygen intake and CO^2 outgo is no indication of fever in any degree. Excessive intake of oxygen and excessive outgo of CO^2 is characteristic, not of fever, but of the pre-tubercular state. Our consumptive patients are burning up their tissues more rapidly than they should and instead of endeavoring to expand their lungs and increase their air capacity we ought to put them at rest. If we do anything with their lungs, strap them down. The patient is oxidizing more of his food than he should and driving it out in the shape of CO^2. The vital machine is not getting sufficient energy, too much is going up the chimney in smoke. Over feeding and rest have, in my judgment, as much to do with the cure of tuberculosis as fresh air.

The only thing that increases in fever is the output of urea. The things that decrease are muscular vigor and secretion of every sort. The secret of fever, so far as I have been able to conclude, is not that we increase oxidation but those processes which are carried on in our tissues without the expenditure of any oxygen at all, processes of decomposition of the food molecule. A molecule which contains from 250 to 2500 atoms, embodies an imense amount of energy. Pull it to pieces and you will get out of it all the energy put into it by the sun. The energy in it is simply the embodied sunshine of past ages, and if the machine knows its business this will be liberated in the form of electrical energy, motion, secretion, with as little possible friction-waste in the form of heat. The cold blooded animal is a greater success from an economical point of view than the warm blooded. We have a few survivals of him occasionally in the so-called centenarian. The centenarian is simply a reincarnation of the mud turtle; he runs his machinery on the smallest possible intake and does the smallest possible amount of work in return.

The change in fever is in the anaerobic action of the tissue-cells. Of all the cells of our body about eight-tenths of them are anaerobic. It is within the factory of these cells, in the processes that may be attended with the absorption, rather than the liberation of heat.

that change takes place in fever; that disturbance of body metabolism which results in the body engine breaking itself to pieces, grinding out its bearings instead of performing its necessary and normal work. The energy which should go to muscular and mental activity, growth and secretion is diverted into and wasted in the production of heat.

What is the mechanism or what is the agent which has this power of utterly paralyzing the body machine and causing it to break itself up? The toxin of some infective disease; or it may be an autotoxin, generated in our own alimentary canal, or by a too rapid breaking down of our own tissues. Any of these will start up reverse operations of the bodily machinery and produce what is called fever.

A toxin acts first of all by depressing the temperature, and fever is a reaction on the part of the body, an attempt to expel that toxin from the body. We are perfectly justified in limiting the excessive rise of heat as far as we can. This action of the toxin I think will explain a good many things about the rise of fever. Most acute infections are attended by distinct shivering, chilliness and sensation of cold. We seldom put a thermometer under the tongue until the patient has begun to warm up. It has been shown by experimentation upon animals that the first result of inoculation with a toxin is to depress the temperature. The malarial organism, the germ of yellow fever, pneumonia, typhoid, all of them tend to depress the temperature, and the patient shivers, feels cold, and if he has been in a draught says that is what did it. The conception of cold as a source of disease owes its origin to this one thing. The chill is the first stage of the disease. One of the things we have most to fight in our attempt to rationalize the public is this baseless dread of cold air.

What attitude can we take toward fever as physicians and therapeutists? First, regard it absolutely as a symptom; to fight fever as such is absurd. It is an indication of the reacting power of an animal. Give a rabbit a small dose of toxin, his temperature rises, quadruple the dose and his temperature will go right down and he will die in collapse and hypothermia. The reacting power is indicated to a considerable degree by the amount of fever and we should avoid fighting against it, lest we should fight one of our best friends. Look for the cause and attempt to remove it. For a long time quinin was considered one of our best fever medicines, for the sole reason that in one of the commonest forms of fever, namely malarial, quinin destroyed the germs, and therefore reduced the temperature. Hence with child-like confidence and credulity we gave it in pneumonia, typhoid, sepsis, even in common colds. It got a reputation as an antipyretic simply because it was a germicide in malaria. Well marked intestinal antiseptics that are absorbed into the blood and neutralize the poison are legitimate as they are really antagonists to the poison. Quinin, salycilic acid, salol and the coal tar products are strong germicides and have probably more or less specific effect upon the germs for which they are most commonly administered.

The method of treating fever by promoting escape of heat by putting our patient in water is also satisfactory. Heat is no advantage to the patient. There is danger in the use of aconite and veratrum; we are simply poisoning the patient so that he cannot react. Whatever we do for the relief of fever we should never do anything that will depress the vital activity of the patient. He will stand any amount of fever better than he will the cardiac depression of aconite or veratrum viride. The cold bath is legitimate and beneficial in other ways besides lowering the temperature. Under some circumstances where the fever is of short duration, where the main thing to combat is discomfort in the patient, I think we are justified in administering small doses, 1½ to 2½ gr. of phenacetin or antipyrin. They will produce as good results in the reduction of temperature as massive doses. Moderate doses of a reasonably harmless remedy I believe are admissable in fever.

Is fever hamful to the tissues of the individual? I believe in most cases we will find that it is not. If that is the case then do not fight fever as such; you are not only fighting one of your best friends but depriving yourself one of your best guides as to the reactive powers of your patient and the course of the disease. Many of our most dangerous germs, such as those of erysipelas, anthrax, typhoid, etc., are decidedly checked in their activity by exposure to a heat of 102° to 104°. It is possible that this rise of bodily heat may limit the activity of the germ. Do not interfere with a fever simply to get rid of the heat. I fear that sadly too much of our treatment of fever in the past has come near justifying Huxley's cynical figure, comparing the battle between the patient and disease to two men fighting in a dark room, and the doctor, to a man with a club striking blindly into the melee, sometimes hitting the disease and sometimes the patient.

THE DIAGNOSIS OF SURGICAL PATHOLOGY IN THE UPPER HALF OF THE ABDOMEN*

By H. D. Niles, M. D.

SALT LAKE, UTAH.

So long as the treatment of surgical pathology in the upper half of the abdomen was limited to the regulation of the diet and the administration of drugs, mistakes in diagnosis might occur without serious loss to the patient or embarrassment to the medical attendant. But since, in the progress of medicine we have learned that certain of the most frequent distressing and dangerous morbid processes of this region may be interrupted or favorably modified by timely operative procedures, all earnest, conscientious physicians have been stimulated to perfect their skill in recognizing early and positively these surgical diseases.

It so happens that nearly all these patients are first under the care of internal medicine men who rarely have opportunities of seeing and studying these processes in life upon the operating table, and who are inclined to view pathology here as they have studied it in the dead house, or who have learned it from popular text-books or from observations made at the bed-side or in the consulting room.

Today I believe all operators are impressed that it is in the operating room, rather than in the dead house or laboratory, that they have received their most helpful lessons in the diagnosis and treatment of the surgical diseases of the upper abdomen. While thus far we have evolved no easily applied and infallible tests for detecting and defining pathology in the peritoneal cavity, we have acquired a new interpretation of well known signs and symptoms that we think aid us in deciding what to do and when to do it.

The practical value of some of these advances have not, to my mind, been sufficiently emphasized by surgeons or appreciated by general practitioners, and it is to a few of these diagnostic aids that I shall venture to briefly call your attention in this paper.

Mental Attitude of Medical Attendant.

First of all, and to my mind, most important, is the mental attitude of the medical attendant. I am sure that if we would form the habit of regarding every obscure abdominal disease as an evidence of an existing pathology that, in the absence of proof to the contrary, was probably surgical, we would reduce the number of errors and delays in diagnosis. This, of course, means a complete reversal of the usual mental attitude of the internist who is prone to view these cases as medical unless overwhelming proof to the contrary is forced upon his attention. If our patients are to reap the full benefits of our advances we cannot be content with simply attaching a name to a disease; we must, as far as we are able, draw a well defined mental picture of the complex and progressive pathologic processes beneath the abdomen, if we are to judge wisely of the time and means for correcting them. In forming this picture we may recall that the stomach, the duodenum, the hepatic curvature of the colon, the gallbladder, the pancreas and the spleen are the organs most likely to be the seat of disease, and the point of greatest tenderness and pain, the presence of a tumor, the history of the case, etc., will usually indicate the organ primarily effected; but we should always bear in mind that progressive morbid processes in this region sooner or later involve the structure, or modify the functions of more than one organ. Hence we should at all times hold ourselves prepared for complications, and on the alert to note and attach value to each of the various symptoms, taking into strict account the order of their successive appearance.

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*Read before the Oregon State Medical Association, Portland, Ore., August 30 and 31, 1904.

For example, stricture, ulceration, or malignant disease of the pylorus, hepatic curvature, or duodenum may have a cholangitis as an antecedent pathology. Cancer of the stomach is usually, perhaps always, preceded by ulcer. Malignant diseases rarely or never attack the gallbladder, liver or pancreas primarily. The causative factors of ulcer of the stomach or duodenum, are not yet determined, but ulcer here, as elsewhere, doubtless depends upon local conditions, which we should strive to recognize.

Significance of Pain and Tenderness.

The exact character and precise location of pain or distress are usually most suggestive indications of the causative pathology. For example, sudden, acute pain in the upper abdomen, accompanied by vomiting and collapse, followed by a circumscribed swelling or tumor always indicates a surgical pathology. The differential diagnosis must then be made between acute pancreatitis, ruptured gallbladder, intestinal obstruction, and perforating, gastric or duodenal ulcer. An acute, long continued pain indicates involvement of the peritoneum. A dull distress over stomach suggests indigestion or retention of gastric contents from pyloric stenosis. Pain extending to right shoulder points to live or gall bladder involvement, while pain in back or left shoulder is oftener associated with disease of the stomach. Attacks of excruciating pain with tender point midway between umbilicus and end of tenth rib, accompanied by chills, point positively to the passage of gallstones.

VOMITING.

Vomiting may be a prominent symptom of any surgical pathology, but is pathognomonic of none, and any disease of the stomach, liver, gallbladder or pancreas may exist without vomiting. The amount ejected and length of time after eating vomiting occurs is significant, but the material vomited is usually unreliable as a sign of disease. Even the presence of blood is not as important an indication as we formerly supposed. The vomiting of large quantities of blood is of course very suggestive of cancer, or ulcer, and the habitual vomiting of food and mucus twenty-four or forty-eight hours after eating points to pyloric obstruction.

DILATATION OF STOMACH ALWAYS A SIGN OF SURGICAL PATHOLOGY.

Marked dilatation of the stomach is, so far as we know, always the result of organic or spasmodic stricture of the pylorus. Such obstructions are nearly always organic and due to either ulcer or cancer; only very exceptionally are they caused by a spasm of the pylorus from an open ulcer. We may know, therefore, that whenever we encounter marked dilatation of the stomach, the condition is not due to atonic dyspepsia or any other theory, but that we are surely facing an actual surgical pathology of some kind, the exact nature and extent of which it is our duty to determine.

TUMOR.

The peculiar shape and characteristic position of a distended gallbladder ought to make this tumor easy to recognize, unless enormously enlarged or greatly distended. Even then, its mobility, consistence, globular outline and attachment to live ought to prevent mistakes. In an old person who is jaundiced, a distended gallbladder points to malignancy, while a contracted gallbladder indicates benign disease. Pancreatic enlargement, growths or tumors are to be recognized by their contour and position just above umbilicus and by exclusion. Artificial distension of the stomach and colon will often aid us in defining the attachment and outline of a tumor in this region. Any tumor or mass apparently connected with the stomach, pylorus or duodenum is regarded by most clinicians as one of the most reliable signs of malignancy. My own observations and comparatively limited experience would lead me to believe this an unwarranted assumption, inasmuch as I have frequently felt and seen, before and during operations, masses in or about the pylorus very difficult to differentiate from cancer, but which proved to be purely the result of an inflammatory or ulcerative process most often associated with an old gastric ulcer. Even the discovery of such tumors, associated or not with glandular involvement, during an operation with an opportunity to feel and inspect the mass, should not lead us to a hasty conclusion for or against malignancy, for, to my mind, it is by no means easy to always differentiate between the benign and the malignant in this region.

LABORATORY TESTS.

Taken alone examinations of stomach contents after a test breakfast, or examination of feces to estimate the fat digestion, and all other chemical and microscopic examinations, afford but little convincing information as to the exact pathology. Taken in connection with other symptoms they may furnish valuable confirmatory testimony. The same may be said of blood and urinary examinations, though the functional activity of the kidneys, or the condition of the blood, might influence us greatly for or against operative procedures. Hence all these tests should be employed in every case but never with an exaggerated idea of their individual value.

SYSTEMIC INFECTION.

Symptoms of mild systemic infection often accompany chronic or sub-acute cholangitis or pancreatitis with or without gallstone seizures, icterus or sever attacks of pain. In the presence of an obscure systemic infection we should always include these organs in our search for the cause. The importance of determining the source of any systemic infection is, as a rule, underestimated, and as a consequence many obscure inflammatory disease of the abdomen are not infrequently treated as typhoid fever, malaria, etc.

It must be admitted by all candid observers that, at the present time, only a small percentage of patients suffering from a surgical pathology in the upper half of the abdomen are permitted to encourage or receive rational treatment—and in only a small proportion of those operated upon is the pathology recognized early enough to give our patients the chances for life and health a timely operation might offer. This is a reflection upon our diagnostic acumen, not our operative skill. Upon the correction of these errors and delays depend the greatest benefits and blessings to be derived from our surgical endeavors in the upper abdomen. The responsibility of employing our present methods of diagnosis to better advantage, or evolving new and more accurate ones, falls largely upon the internist. The surgeon has already demonstrated his willingness, and to a large extent his ability, to cope with this pathology, but our next greatest advances are yet to come, and they must come from an earlier and more accurate mental picture of the orbid conditions at the hands of our colleague, the internal medicine man.

NOTES ON TREATMENT OF GONORRHEA.

By W. B. Parsons, M. D.

Missoula, Mont.

For many years it has become more and more apparent to me that gonorrhea is a much more serious disease than is generally supposed. It causes more suffering and more deaths than syphilis —especially in the female sex. It is no exaggeration to say that one-half of the female diseases of the pelvic region are caused by it, inflammation of the womb, salpingitis, ovaritis and pelvic abscess being the most common. Various persons often say that they would just as soon have gonorrhea as a bad cold, but I have noticed that when they get through with it, the bad cold is always preferred.

Missoula gonorrhea and, in fact, that of all other western cosmopolitan towns, where almost every nation on the earth is represented, is of a peculiarly violent and aggravating nature. Occasionally a case is presented that is cured within the old regulation time, eighteen days, but it is very rare. The great majority, no matter how treated, run from three weeks to three months and even longer and, when I get hold of such, I am reasonably sure that a nigger, a Chinawoman or an Indian has had a "finger in the pie"—probably not at first hand but at some past act of fornication. The regular, old, down South white folks clap was limited, under fair treatment, to eighteen days.

My treatment of these cases has included every remedy that was ever proposed on earth. Seeing that none of them cut it short, I began to use various untried medicines and, for two years my treatment has been purely experimental. I have tried bicarbonate of soda, made in bougies, with negative results. Knowing that neither animal nor vegetable life can be long maintained in a saturated solution of common salt, I had some soluble bougies made, of a fifty per cent. strength, about four inches long. In several cases the discharge was profuse and purulent. The urethra was washed out with warm, sterilized water and a four per cent. solution of cocain. introduced and retained for three minutes. A salt bougie was then introduced and held in place by cotton over the glans, confining the penis in an upright position, till absorption had taken place. A most remarkable effect of it is an almost complete transformation from a purulent to a mucoid discharge. But, so far as my limited experience goes, the recovery is not hastened.

Recently, after cleansing and cocainizing the urethra, which was discharging great quantities of pus, I injected 1 dr. of a 25 per cent. sol. of sulpho-hydrate of soda. This was done because the remedy—medicine or, whatever it should be called—is known to destroy hair beneath the skin and it led me to believe that probably it would kill the gonococci, burried beneath the mucous membrane. By retaining it for about three minutes a most profuse, stringy, mucous discharge was produced, continuing for two hours or more. This has been tried in two cases and the results, so far, are eminently satisfactory. No discharge of pure pus has appeared since.

When the penis is inflamed and swollen and urination is difficult and painful, an injection of ½ dr. of a 4 per cent. sol. of cocain, with 15 drops of adrenalin, held for three or four minutes, gives wonderful relief and reduces the size of the penis one-fourth to one-third or more.

Many competent and intelligent physicians contend that, like small pox, measles, etc., gonorrhea is a self limited disease. Barring complications, my experience substantiates the position taken. Aside from any asserted sure cure and after many years of experience, I can say that the must successful treatment is complete rest—better in bed—a bland diet, nothing but water and milk to drink, the bowels to be kept loose with Rochelle salts, a diuretic as acetate of potash and for chordee ¼ gr. calcium sulphide every three hours.

CLINICAL REPORT.

EARLY DIAGNOSIS OF ADENO-CARCINOMA OF THE FUNDUS UTERI.

By Elmer E. Heg, M. D.

SEATTLE, WASH.

Mrs. B. R.; White, Canadian, age 58, widow. Father died, age 78, of diabetes; mother, at 64, cause unknown, but patient is positive it was not cancer; one brother living about 60, in good health; three sisters died of tuberculosis.

Personal History.—Never pregnant; menstruation began at 15, menopause occurred at 51. Menstruation always very painful and flow very profuse. Received a slight injury to back from a fall at 18; had diphtheria at 19; pneumonia at 27; several severe uterine hemorrhages at 49, or nine years ago, at which time a fibroid tumor was removed from back of uterus through vagina. Menopause occurred two years later and there was no exceptional severity of the flow during those two years. Was operated for hemorrhoids at 56. In August, 1903, had a slight flow from uterus, following a severe diarrhea, which lasted only a portion of one day. About five months later she had a slight flow which lasted, with intermissions, for several days. Another slight hemorrhage occurred in about a month or so, and again when she came under my observation, in February, 1904. At that time there was no indication of any hemorrhage, though she stated she had flowed a little in the morning.

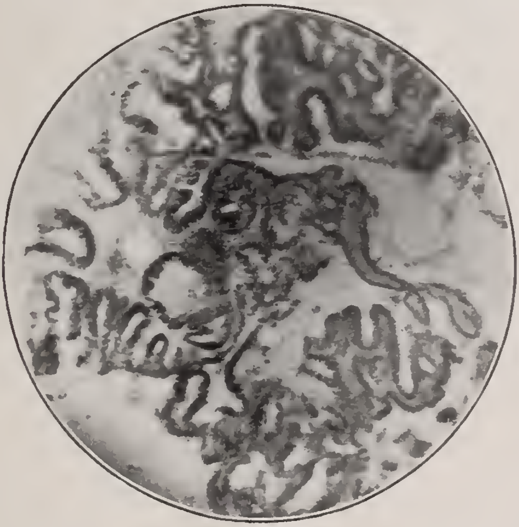

Fig 1.

Adeno-Carcinoma of fundus from curetting (Bausch & Lomb. 2-3).

Physical Examination revealed a very small vagina and a small, hard, apparently senile uterus, which was only slightly movable but otherwise normal. In fact, nothing abnormal was found. The only symptom other than hemorrhage she complained of was an irritation or, rather, an "uneasy sensation" of the bladder. Examination of the urine showed nothing abnormal.

Curettage for diagnosis was advised and agreed to, but owing to various circumstances the patient was not at the time able to have it done. She came again April 15 with a report of a slight hemorrhage, and again May 6, at which time she reported a severe hemorrhage the day before which had lasted several hours. At no time was there evidence of any bloody discharge in the vagina or on her pads. May 22 she appeared and was ready for curettment. At that date I asked Dr. C. A. Smith to see her, and he confirmed my statement that all the pelvic organs were apparently normal, but on account of the hemorrhages it would be advisable to curet for diagnostic purposes.

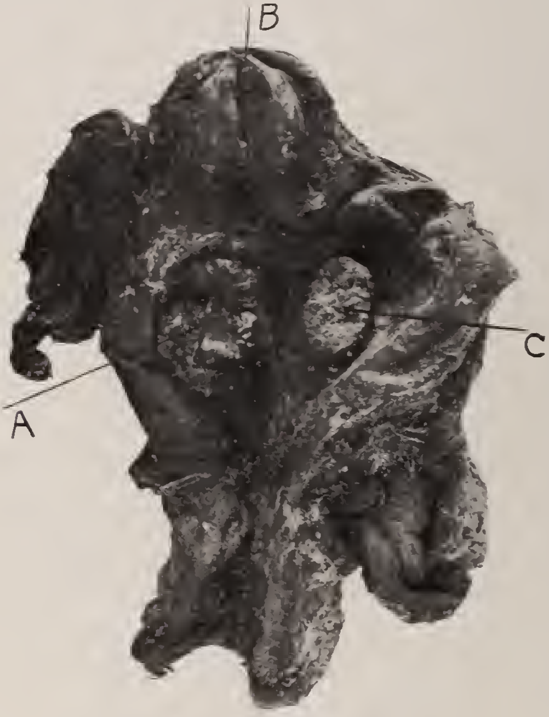

Fig. 2. (Natural size.)
A, Adeno-Carcinoma; B, Fibroid; C, Polyp.

Curettment was done May 26, with the understanding if a malignant growth was found an operation for removal was to follow very shortly. While curetting I noticed a soft spot high up, near the right horn of the uterus which, in fact, was the only place any material was easily removable. All debris was saved in a 2 per cent. formalin solution and given Dr. Smith for examination. He reported this to reveal a typical adeno-carcinoma, of which Fig. 1 is an illustration, being a micro-photograph made by Dr. S.J.Holmes. An abdominal hysterectomy was done June 6. The patient made an uninterrupted recovery and returned to her work as a cook about six weeks later, feeling better than she had for a long time.

The pathologic specimen obtain is shown in Fig. 2. The uterus was 8 cm. long by 5 cm. in breadth; the cavity 7 cm. in depth. Above the right cornu was a globular, subserous tumor, 20 mm. in diameter, supposed to be a projection from the carcinoma, but which proved to be a fibroid. On the posterior surface was another fibroid the size of a pea. Near the right cornu, as supposed from the curetting, was an oval tumor, 20x15 mm., an adeno-carcinoma. At left cornu was an oval pedunculated tumor, smaller than the carcinoma, attached by a small pedicle. The microscope showed this to be a polyp.

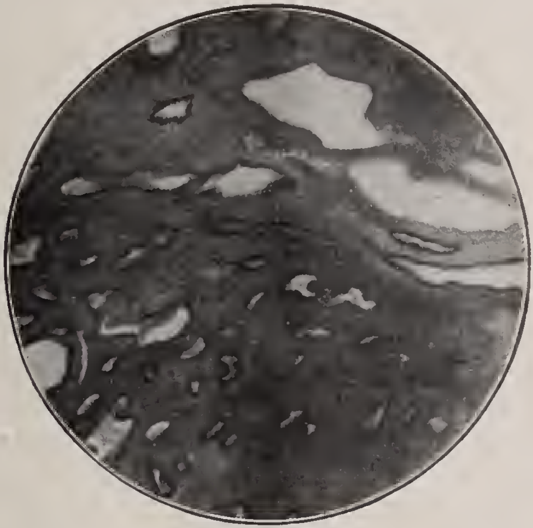

Fig. 3.
Uterine Polyp, Showing Hypertrophied Glands. A Section from C. Fig. 2 (Bausch & Lamb, 2-3).

As stated before, there was never pain or other symptom, except the bladder "uneasiness," and no discharge except the hemorrhages noted, of which the evidence was so slight, until May 5, as to raise a doubt whether or not it came from the uterus. This case, however, clearly illustrates the importance of immediate curettage for any hemorrhage, no matter how slight, that occurs after the menopause and the saving of all debris for microscopic examination. It also brings out the fact that a carcinoma of the body of the uterus can exist for a comparatively long time almost without symptoms, and that an early diagnosis can be made only by these means.

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ARE URINARY FINDINGS DECISIVE?

Some observations of Dr. R. C. Cabot, of Boston, made at a recent meeting of the Johns Hopkins Medical Society*, are worthy of extended notice.

The general tenor of Cabot's remarks is to caution against too great reliance in making a diagnosis, solely upon the so-called exact methods of examination. There is now among the younger and highly educated physicians a tendency to neglect the more general time-worn and broad clinical data for exact methods—a natural reaction from the older and looser modes of practice. To point his moral and adorn his tale he mentions a case of a woman who developed digestive disturbances, whereat her physician "made an exhaustive examination of the abdomen, extracted the contents of the stomach, examined them, measured the size of and marked out the position of the stomach, analyzed the urine quantitatively, examined the blood, made an estimate of the hemoglobin, and prescribed for the patient." It turned out subsequently that the patient was pregnant. It might have been impossible to determine pregnancy by any examination but a careful history might have enabled a probable diagnosis at the time the patient was seen.

To come to the matter in hand, Cabot details the history of two patients in the Massachusetts General Hospital. In the first case there was unconsciousness, temp. 102.8°, some retraction of head and stiffness of neck, and slight consolidation of one apex. Cerebro-spinal meningitis was suspected but lumbar punctures gave no growth. Urine showed high-colored urine, spec. gr. 1017, sediment, 10 to 20 granular and epithelial casts in every field, albumin over ½ per cent. Blood examination negative. Autopsy revealed cerebro-spinal meningitis. An expert pathologist found the kidneys absolutely normal.

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*Bull. Johns Hopkins Hosp., May, 1904.

In case 2 there had been a surgical operation and following it the urine, which had been normal, fell to 15 ounces in the 24 hours and contained .7 per cent. albumin. Casts were numerous, including waxy and highly refractive ones. The patient died at the end of a week with the diagnosis of uremia. Autopsy showed the kidneys absolutely normal, miscroscopically and macroscopically. Then Cabot went over the records of the hospital for ten years previous, picked out cases which showed definite lesions of the kidneys at autopsy and looked up their histories to determine how often these lesions could have been discovered during life. Next he took the number in which the kidneys were found normal at autopsy and compared their clinical histories. In every case the kidneys were examined at autopsy microscopically by an expert and the urinary examinations were likewise unimpeachable.

The results are most interesting and surprising. Out of the 19 cases of acute glomerular nephritis, as found as autopsy, only five were recognized during life and in these there was edema. In 17 cases of chronic glomerular nephritis, post mortem, 15 were correctly diagnosed during life. In many of these the urine was wholly negative and the diagnosis was made from the clinical picture which is so characteristic in this disease. But—most astounding of all—of the 37 cases of chronic interstitial nephritis, only 14 were diagnosed as some type of nephritis; four were diagnosed as chronic interstitial nephritis, and the remainder were not diagnosed as any kind of nephritis whatever. Only a little over one-third of the cases of chronic interstitial nephritis were diagnosed as such during life, in one of the best hospitals in the country.

Cabot says he does not know how there is any getting round these bare statistics. We heartily agree with him. Two other common sources of error are pointed out by Cabot. First, that the thickness of the alubumin-zone in the nitric acid test is no criterion to follow unless we know the tewenty-four hour amount. With a large zone and small amount of urine there may be less albumin than with a small zone and a large secretion of urine. However, it is admitted that a low percentage of albumin, without regard to the exact amount in the twenty-four hours, indicates a better condition of the kidneys than a high percentage. Second, that the quantitative estimation of urea is comparatively valueless unless the character and amount of food is taken into account and the metabolic activities generally. Seventy per cent. of persons over forty years of age have casts in their urine and Osler has showed that this is of advantage to them. Suffice it to say, that there may be, as Welch pointed out, marked lesions of the kidney post mortem without albuminuria and casts, and conversely there may be albuminuria and casts without demonstrable structural alterations of the kidney.

MEMBERSHIP OF THE WASHINGTON STATE MEDICAL ASSOCIATION.

The following list of members, for the current year, is compiled from the records of Secretary Coe. It is to be noted that this membership is materially less than that of last year, numbering 264, while the latter was considerably above 300. Furthermore, under the old state society, the nominal membership included over 400. This simply means that, under the present organization of our medical societies, the rules and regulations of the constitutions are being carried out to the letter. The first consideration for good standing in the local society is payment of annual dues. Failing in this, one forfeits his membership in the State Association and the American Medical Association, since the state secretary can enroll as members only those names passed up to him by the local secretaries and only these can be certified as in good standing for the parent association.

The fiscal year of this Association ends with the calendar year, at the end of which dues should be paid. The by-laws direct the secretaries to report their lists of members by May 1, of the following year, with dues for each, to the State Association.

In this list will be noticed the absence of the names of some prominent physicians of the state, the explanation of which has already been given. Whether the responsibility for this condition rests more with the secretaries or individual members we will not attempt to judge, but its remedy is clear and, we trust, will be applied hereafter.

MEMBERS OF THE STATE ASSOCIATION FOR THE YEAR 1904.

CHEHALIS COUNTY.

W. L. Pearson, Aberdeen.
J. W. Scamell, Aberdeen.
D. A. Schumacher, Aberdeen.
M. R. Stapp, Aberdeen.
J. R. Walkins, Aberdeen.
H. Blair, Elma.
C. P. French, Elma.
H. Campbell, Hoquiam.
A. J. McIntyre, Hoquiam.
H. C. Watkins, Hoquiam.
W. B. Wells, Hoquiam.
F. L. Carr, Montesano.
J. S. Waltson, Montesano.

KING COUNTY.

D. M. Stone, Black Diamond.
H. H. Rust, Enumclaw.
J. J. Smith, Enumclaw.
W. P. O'Rourke, Georgetown.
S. A. Woodin, Georgetown.
R. J. James, Mackay.
I. A. Beach, Renton.
H. E. Allen, Seattle.
J. W. Bailey, Seattle.
E. L. Bickford, Seattle.
J. R. Booth, Seattle.
F. M. Carroll, Seattle.
F. M. Conn, Seattle.
H. J. Clark, Seattle.
C. B. Cowan, Seattle.
W. F. Cunningham, Seattle.
R. M. Davis, Seattle.
L. R. Dawson, Seattle.
S. J. Dean, Seattle.
J. B. Eagleson, Seattle.
E. R. Edson, Seattle.
O. Edwards, Seattle.
F. Falk, Seattle.
C. B. Ford, Seattle.
J. H. Fleisher, Seattle.
F. P. Gardner, Seattle.
W. E. Gibson, Seattle.
R. H. Gillen, Seattle.
J. E. Harris, Seattle.
A. B. Harrison, Seattle.
I. M. Harrison, Seattle.
W. C. Hastings, Seattle.
A. W. Hawley, Seattle.
G. W. Hawley, Seattle.
E. E. Heg, Seattle.
W. C. Heussy, Seattle.
C. Hoffman, Seattle.
S. J. Holmes, Seattle.
G. M. Horton, Seattle.
C. E. Hoye, Seattle.
I. Janson, Seattle.
W. Johnston, Seattle.
A. B. Kidd, Seattle.
C. Harden, Pe Ell.
J. W. Bean, Ellensburg.

LEWIS COUNTY.

H. G. Lazelle, Seattle.
G. Lewis, Seattle.
A. O. Loe, Seattle.
J. B. Loughary, Seattle.
W. L. Ludlow, Seattle.
J. H. Lyons, Seattle.
M. Marsh, Seattle.
G. B. McCulloch, Seattle.
M. E. A. McKechnie, Seattle.
J. A. McKinnon, Seattle.
G. N. McLlaughlin, Seattle.
J. H. McLeish, Seattle.
W. T. Miles, Seattle.
H. D. Miller, Seattle.
D. A. Mitchell, Seattle.
J. C. Moore, Seattle.
J. B. Mott, Seattle.
M. F. Nadeau, Seattle.
E. C. Neville, Seattle.
L. C. Neville, Seattle.
H. C. Ostrom, Seattle.
S. A. Owens, Seattle.
W. M. Patterson, Seattle.
R. W. Perry, Seattle.
G. S. Peterkin, Seattle.
N. D. Pontius, Seattle.
F. L. Powell, Seattle.
W. N. Powers, Seattle.
G. H. Randell, Seattle.
A. Raymond, Seattle.
H. M. Read, Seattle.
J. Richter, Seattle.
R. R. Ross, Seattle.
M. Russell, Seattle.
R. W. Schoenle, Seattle.
C. W. Sharples, Seattle.
J. Shannon, Seattle.
W. A. Shannon, Seattle.
C. A. Smith, Seattle.
R. M. Stith, Seattle.
J. E. Stevens, Seattle.
H. Stillson, Seattle.
J. P. Sweeney, Seattle.
C. H. Thomson, Seattle.
G. A. Tripp, Seattle.
G. F. Warmburg, Seattle.

KITTITAS COUNTY.

K. Winslow, Seattle.
J. Wotherspoon, Seattle.
F. B. Whiting, Seattle.
P. W. Willis, Seattle.

PACIFIC COUNTY.

G. W. Overmeyer, South Bend.

PIERCE COUNTY.

W. Douglas, Puyallup.
J. H. Corliss, Sumner.
C. M. Parks, Steilacoom.
L. Perkins, Steilacoom.
H. Allen, Tacoma.
J. Armstrong, Tacoma.
C. P. Blabanoff, Tacoma.
I. P. Blabanoff, Tacoma.
M. L. C. Blabanoff, Tacoma.
E. M. Brown, Tacoma.
J. R. Brown, Tacoma.
W. Brown, Tacoma.
W. Brown, Tacoma.
C. E. Case, Tacoma.
A. H. Coleman, Tacoma.
T. B. Curran, Tacoma.
H. W. Dewey, Tacoma.
E. J. Fifield, Tacoma.
R. A. Gove, Tacoma.
A. deY. Green, Tacoma.
R. H. Harrison, Tacoma.
G. S. Hicks, Tacoma.
F. R. Hill, Tacoma.
J. Kehoe, Tacoma.
C. H. Kinnear, Tacoma.
G. A. Libby, Tacoma.
O. W. Loughlen, Tacoma.
L. L. Love, Tacoma.
F. S. Lowell, Tacoma.
C. McCreery, Tacoma.
W. McCreery, Tacoma.
C. H. McCutcheon, Tacoma.
G. W. McGreer, Tacoma.
J. J. McKone, Tacoma.
J. B. McNetherney, Tacoma.
A. Osborn, Tacoma.
C. Quevli, Tacoma.
W. D. Read, Tacoma.
T. C. Rummel, Tacoma.
J. L. Rynning, Tacoma.
S. Sargentich, Tacoma.
F. J. Schug, Tacoma.
F. A. Scott, Tacoma.
G. D. Shaver, Tacoma.
J. H. Spencer, Tacoma.
F. J. Stewart, Tacoma.
P. B. Swearingen, Tacoma.
E. A. Trommald, Tacoma.
M. F. VanBuren, Tacoma.
G. C. Wagner, Tacoma.
R. D. Wilson, Tacoma.
P. B. Wing, Tacoma.
J. R. Yocum, Tacoma.
J. J. Sturgus, Vashon.
C. E. Taylor, Wilkeson.

SKAGIT COUNTY.

G. E. Howe, La Conner.
R. J. Cassel, Mt. Vernon.
F. B. West, Mt. Vernon.
C. C. Harbaugh, Sedro-Woolley.
J. Jones, Sedro-Woolley.
M. B. Mattice, Sedro-Woolley.

SNOHOMISH COUNTY.

E. W. Adams, Arlington.
B. L. Baker, Everett.
J. R. Hathaway, Everett.
J. L. Manning, Everett.
D. McEchran, Everett.
J. S. Newcomb, Everett.
F. S. Sanborg, Everett.
J. E. Stauffer, Everett.
W. F. West, Everett.
C. L. Munn, Marysville.
E. L. Stephens, Monroe.
J. A. Durrent, Snohomish.
A. K. Luen, Snohomish.
O. S. Allen, Stanwood.

SPOKANE COUNTY.

H. W. Allen, Spokane.
N. M. Baker, Spokane.
T. L. Catterson, Spokane.
A. H. Coe, Spokane.
A. B. Cook, Spokane.
P. A. Downsnack, Spokane.
N. F. Essig, Spokane.
B. R. Freeman, Spokane.
G. A. Gray, Spokane.
M. B. Grieves, Spokane.
A. P. Johnson, Spokane.
G. W. Libby, Spokane.
C. Lieberg, Spokane.
H. B. Luhn, Spokane.
D. Mason, Spokane.
G. K. McDowell, Spokane.
A. F. McLeod, Spokane.
E. D. Olmstead, Spokane.
G. T. Penn, Spokane.
F. Poor, Spokane.
W. W. Potter, Spokane.
J. M. Powell, Spokane.
E. T. Richter, Spokane.
F. Rose, Spokane.
J. M. Semple, Spokane.
M. F. Setters, Spokane.

H. H. Slater, Spokane.
J. Sutherland, Spokane.
R. L. Thomson, Spokane.
A. F. Tilmont, Spokane.
F. P. Witter, Spokane.
S. Yarnell, Spokane.

WALLA WALLA COUNTY.

N. G. Blalock, Walla Walla.
Y. C. Blalock, Walla Walla.
J. E. Bingham, Walla Walla.
J. F. Cropp, Walla Walla.
C. A. Hauber, Walla Walla.
H. R. Keylor, Walla Walla.
A. W. Lueders, Walla Walla.
M. A. Nelms, Walla Walla.
W. E. Russell, Walla Walla.
E. E. Shaw, Walla Walla.
C. B. Stewart, Walla Walla.
W. H. Van Patten, Walla Walla.

WHATCOM COUNTY.

W. H. Axtell, Bellingham.
H. J. Birney, Bellingham.
D. E. Briggs, Bellingham.
H. E. Henderson, Bellingham.
C. L. Holt, Bellingham.
W. N. Hunt, Bellingham.
S. H. Johnson, Bellingham.
W. D. Kirkpatrick, Bellingham.
A. T. Knapp, Bellingham.
L. R. Markley, Bellingham.
A. B. McKinnon, Bellingham.
A. M. Smith, Bellingham.
H. Thompson, Bellingham.

WHITMAN COUNTY.

W. N. Devine, Elberton.
T. D. Ferguson, Colfax.
W. Johnston, Colfax.
W. A. Mitchell, Colfax.
R. J. Skaife, Colfax.
A. E. Stuht, Colfax.
J. L. Harris, Colton.
J. D. Leuty, Farmington.
W. S. Gains, Oakesdale.
W. Farnham, Palouse.
E. T. Hein, Palouse.
A. A. Benton, Pullman.
J. F. Hall, Pullman.
E. Maguire, Pullman.
C. H. Russell, Pullman.
W. E. White, Pullman.
G. B. Wilson, Pullman.
C. James, Tekoa.
C. S. Bumgarner, Thornton.
R. Banks, Uniontown.
C. A Holzer, Uniontown.

YAKIMA COUNTY.

E P. Helliker, North Yakima.

TO OUR READERS AND CONTRIBUTORS.

All material for publication must be received by the twentieth day of the month preceding a given issue. Articles will be illustrated by half-tones or etchings when accompanied by photographs or drawings for the same. Reprints of contributed articles can be obtained at the cost of publication, from the Metropolitan Press, publishers of the Journal. A limited number of additional copies of the Journal will be supplied to contributors, if a request is made for them.

TO ADVERTISERS.

We wish to call attention to the fact that NORTHWEST MEDICINE has no department for reading notices, publishers' notes, etc., and that the literary and advertising pages are entirely distinct.

OBITUARY

Alexander Rudolph Becker, M. D.

Dr. Becker was born in Hamburg, Germany, Dec. 30, 1841. He came to this country a year later, his father having been appointed Russian Consul General at New York He was sent abroad at sixteen to travel and, on his return, entered the University of New York Medical School, graduating in 1861. He was thereafter special pupil and assistant of Dr. John Murray Carnochan, of New York, the eminent surgeon. In the spring of 1862 he was appointed Assistant Surgeon, with the rank of second lieutenant, and attached to the staff of General Geo. B. McClellan. He was soon after appointed executive officer of the White House (field) Hospital, in Virginia, serving as such under command of Brigade Surgeon (Lieut. Col.) Baxter (afterwards Surgeon General, U. S. A.), untel the latter was sent North disabled by illness. Dr. Becker was then placed in command and so served until disabled by dysentery and typhoid and sent North. He never recovered from the effects of that illness. He was ordered abroad to travel and reported again for duty in 1864.

After the war ended he settled in Providence, R. I., where he practised till the spring of 1876. His health being very much broken he went to California, arriving at San Francisco, May, 1876. Here he practised for two years, when he was forced to retire on account of ill health. He was an invalid for many years, but wrote on medical subjects from time to time, always maintaining his reading.

He moved to Seattle in May, 1899. In the fall of that year his health being improved, he went to Philadelphia and took special courses in pathology. On his return, in 1900, he established a pathologic laboratory in Seattle and became well known in the State of Washington as a specialist in this line of work. In the spring of 1903 he concluded entirely to abandon medical work. Accordingly he presented his laboratory and pathologic library to the King County Medical Society, hoping that it might prove a means for good and useful work as well as for scientific investigation.

Early in this year he went East and thence to Europe. He expected to study in Vienna but while there a stricture in the colon (a result of the attack of dysentry in 1862) became severely inflamed. As soon as he could travel he hastened back to Seattle. The trouble continued, causing intense and continuous suffering.

He left Seattle for Victoria, B. C., in January, 1904, and there lived with his son. His work was over, though he always hoped that he might recover sufficiently to take it up again. His health seemed to improve materially in June last and through the summer he again entered keenly into social pleasures. He severly overtaxed his strength however, in attending a reception given to the visiting physicians at the Parliament buildings, Victoria, on Aug. 26. His trouble became very acute. He was apparently recovering from his last attack when peritonitis occurred on Friday evening, Sept. 2. He became unconscious and died in a few hours.

Dr. Becker was a member of the Massachusetts Commandery of the Military Order of the Loyal Legion; of the Society of the Army of the Potomic: and of the University Club of Seattle.

CORRESPONDENCE.

WHY SHOULD THE DRUGGIST CO-OPERATE WITH THE PHYSICIAN?

To the Editor: So much has recently been said regarding the relation of the druggist to the physician, from a medical standpoint, that I think the druggist should have a few words to say.

There is no doubt that there are a great many druggists who prefer to sell their customers patent medicines and even prescribe over the counter, but yet I know there are more druggists who would rather co-operate with the physician.

In the first place, the profit on a prescription written by a physician is larger that that from the sale of a patent medicine. In the second place, the druggist does not assume any responsibility, and thirdly, it is contrary to all rules of etiquette to counter prescribe. I always feel better satisfied after having recommended a customer to a physician, even though there is no financial result, for then I feel that I have treated the practitioner with due courtesy. Only in rare cases, when I am sure to lose my customer, will I sell patent medicine.

The present agitation against patent medicines will not abolish this evil but will increase the sale of proprietary medicines. The patent medicine of the future is the one that will be advertised only to doctors. The best selling remedies at the present time are of this class. All their publicity is secured through the medical press, by means of the manufacturers literature, through medical journals and samples to doctors.

Very little skill is required today from the druggist to fill prescriptions, for three-fourths of all prescriptions received are for these proprietary remedies. All the druggist has to do it to open the package and put on the label. In some cases the original bottle is given to the patient. Very frequently the physician will give to his patient the original sample bottle. The patient has received a benefit from it; it has done him good; he goes to a drug store with the empty sample bottle, and calls for an original of the medicine invariably with the excuse, "I don't want to trouble the doctor." Not only that, he recommends it to his friends with the words, "Best thing in the world, my doctor has prescribed it for me, it is not a patent medicine." In this way the physician is cheated out of his fee.

The name of the remedy, advertised only to the physician, becomes known to the public, and I have no hesitancy in saying that for every sample bottle we sell four original bottles over the counter without prescriptions. Who reaps the harvest? The manufacturers of these proprietary articles, the medical journals, and a small profit to the druggist.

I stated my reasons why a great many druggists and myself would rather co-operate with the physician than against them, and repeat again that every well meaning druggist will use his best effort to make the relation of the druggist to the physician result in mutual benefit.

MAX RAGLEY.

Seattle, Wash.

REPORTS OF SOCIETY MEETINGS.

KING COUNTY MEDICAL SOCIETY.

President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

The first regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce, on the evening of Sept. 5, President Heg being in the chair.

PATHOLOGIC CASES.

A Small Intra-Uterine Fibroid With Extensive Hemorrhage.—Dr. Horton presented a specimen from a woman, 42 years of age, who consulted him on account of hemorrhage. He treated her by rest in bed, ergot, adrenalin, etc., for six months. She declined an operation till the bleeding became so profuse that she nearly bled to death. Then he performed a vaginal hysterectomy. The specimen was that of a uterus of normal size. At the fundus was a small tumor, about the size of a pea. He called attention to the severe hemorrhages that could arise from so small a growth. He did not curet at any time.

A Large Friboid of the Cervix With Severe Hemorrhage.—Dr. Smith presented a specimen from a woman, 47 years of age, who still menstruated regularly. During last June and July she had several profuse hemorrhages, which caused her to lose consciousness and resulted in marked anemia. Vaginal examination showed a large tumor situated in the posterior wall of the cervix and partly filling the vagina, tilting the os forward under the pubes. On admission to the hospital, the middle of July, the hemoglobin was reduced to 30 per cent.; red cells, 3,860,000; whites, 10,000. Under rest in bed, iron and arsenic, the hemoglobin rose to 50 per cent. in a week. Abdominal hysterectomy was performed. The specimen was 7½ inches long, only a little over an inch being fundus and the remainder the elongated cervix, containing a large fibroid, situated wholly in the posterior wall, Attention was called to the large size before symptoms of hemorrhage' appeared and its peculiar situation.

Adeno-carcinoma of the Fundus Uteri.—This was presented by Dr. Heg (see page 447).

Dr. Harris referred to his lack of success in the internal treatment of hemorrhage with adrenalin. He had failed to obtain any effect on the bleeding by its administration.

Dr. Horton mentioned a case with large friboid, much exhausted by hemorrhage, whose operation was delayed in order to build her up, in whom the bleeding was perfectly controlled by this remedy.

Dr. Read called attention to the fact that permanent diabetes had been occasioned by its administration and that it should be used with caution. He emphasized the importance of always seeking the cause of an unusual bloody uterine discharge. A thorough curetting should then be done and the scraping submitted to the examination of a competent pathologist.

The discussion was continued by others.

The second regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce on the evening of September 19, President Heg being in the chair. Twenty-five members were present.

The names of Drs. R. L. Keith, Wm. McDowell and C. F. Engle were presented for membership.

CLINICAL CASE.

Albuminuric Retinitis.—Dr. Heussy presented the case, a boy of 9 years. He had been well till 6 years of age, when he had what his mother called a "low fever." After recovery from this he was in good health till last June, when he was troubled with headache and vomiting, for which he received rhubarb, calomel and soda. Three weeks later he became partly blind. He was presented to Dr. A. W. Hawley, who diagnosed retinitis. Otherwise he complained of nothing. His brother, of 12 years, has had chorea for eight weeks. Urinary examination was as follows: Acid, sp. gr. 1018, trace of albumin, no sugar, no bile, urea 1.13 per cent., a few hyaline and fat casts.

Dr. Hawley stated that on this day he had examined him and found the usual appearance of retinitis, with a single point of hemorrhage. When he first saw him these were numerous. At that time his vision was 6-18. Now he can only distinguish light from darkness.

Dr. Stillson said that usually, early in the disease, the patient does not think there is anything the matter with the eyes or kidneys. He has attacks of blindness which pass off. He usually enquires whether they have had the "blind staggers." They generally think they have biliousness or indigestion. If this is a case of albuminuric retinitis that has advanced to atrophy of the retina, he will probably die. He thought there was probably other cerebral condition beside uremia, because until recently there has been no albumin. It is very likely syphilitic.

Dr. Janson mentioned the case of a pregnant woman who became blind for two days and then recovered. No albumin was found in her urine.

Dr. Pontius thought the case probably retinal, there being some depression of the optic nerve.

PATHOLOGIC CASE.

X-ray of Foreign Body.—Dr. Sharples exhibited a plate of a boy 14 years of age. Nine years ago he swallowed a cross bar of a watch chain. He was given cathartics, but the bar was never recovered. Two years ago he began attacks of pain, vomiting and diarrhea, suggestive of appendicitis. Recently he consulted the doctor, who had this plate taken by Dr. Thomson. It shows the bones of the pelvis and a shadow suggestive of the lost bar. The doctor massaged the right iliac region and when other radiographs were made, this shadow did not again appear.

CHEHALIS COUNTY MEDICAL SOCIETY.

President, D. A. Schumacher, M. D.; Secretary, M. R. Stapp, M. D.

The third regular quarterly meeting of the Chehalis County Medical

Society was held on the evening of October 4, 1904, at the office of Dr. I. R. Watkins, at Aberdeen.

PROGRAM.

Diarrhea of Children and Adults During the Summer Season.—This paper was read by I. R. Watkins. A discussion followed by all members present.

Radical Operations for Empyema.—This paper was read by A. J. McIntyre, of Hoquiam. The discussion was led by Dr. M. Rob. Stapp, of Aberdeen, and Dr. French, of Elma.

WHATCOM COUNTY MEDICAL SOCIETY.

President, D. E. Biggs, M. D.; Secretary, W. N. Hunt, M. D.

The regular monthly meeting of the Whatcom County Medical Society was held at the Odd Fellows' building, in Bellingham, September 12, 1904. Dr Van Kirk, Vice-President, occupied the chair.

The application for membership of Dr. C. O. Reed was presented and referred to the appropriate committee.

On motion of Dr. Kirkpatrick the vacancy in the Committee on Admission and Ethics, caused by the removal of Dr. Gosnell, was filled by the election of Dr. Hunt to that position.

Intestinal Paresis.—The paper of the evening was contributed by Dr. W. H. Axtell on the subject of Intestinal Paresis. The doctor referred especially to cases following surgical operations and confinements and stated that they were often fatal and responded slowly, if at all, to medication.

The paper was discussed by Drs. Biggs, Kirkpatrick, Smith and Thompson.

Adjourned to meet October 10.

RECENT PROGRESS IN MEDICINE AND SURGERY.

INTERNAL MEDICINE.

Edited by

C. W. Sharples, M. D.; H. M. Read, M. D.

Clinical Features of Cerebro-Spinal Meningitis.—By Henry Koplik, M. D., Medical News, June 4, 1904.

This article calls particular attention to certain clinical types of the disease and especially that of the temperature, which varies a great deal, being more or less intermittent, sometimes running up a range of four, five, six or eight degrees in a short space of time. In some cases the temperature runs along not over 101°, in which cases nervous symptoms may or may not be very marked. He also makes mention of cases which, from the temperature curve, might have been mistaken for an ordinary attack of intermittent fever, such condition being without nervous symptoms, and in those cases the diagnosis was only made from a lumbar puncture. The neck rigidity is not a constant symptom, being present in only about 70 per cent., though the other 30 per cent. would probably present slight or marked rigidity at some time or other during the attack. The reflexes are present during the early stages of the disease and rapidly disappear in fatal cases. The Babinski reflex, caused by extension of the great toe on irritation of the plantar surface of the foot, is present in about 77 per cent. of the cases of tubercular meningitis, which probably would serve as a differential diagnostic point between cerebro-spinal meningitis and the tubercular form, but is not a sign of very much value in children and infants below 2 years of age and may at times be seen in perfectly normal infants.

The Kernig symptom is also of very little use in children below 2 years of age and is not a constant sign even in adult cases. Children are very apt to lie with their limbs flexed.

In an epidemic just experienced in New York the hyperesthesia of the skin and mental irritability were marked symptoms. The MacEwen sign, in which a hollow sound is given out when percussion is made over the anterior horn of the ventricle, is supposted to depend upon a collection of fluid in that organ and consequently more frequently found in tubercular cases, and it occurs in some of the cerebro-spinal cases. In a majority of cases seen by the writer the rash usually described was not present. In every case he mentioned there was leucocytosis to some extent. The fatality was not so universal as we are accustomed to suppose it to be in epidemics of this disease. Quite a large percentage, compartively speaking, recover. It may be, or it probably is, a fact that the majority of us only make a diagnosis of cerebro-spinal meningitis from the clinically typical forms of the disease and do not depend upon the results of the examination of the fluid obtained by the lumbar puncture, which of course is a positive method of making diagnosis. Sharples.

Kernig's Sign. By J. L. Miller, M. D., Am. Jour. Med. Sciences, June, 1904.

In his review of this valuable aid to diagnosis of meningeal inflamations, after referring to Kernig's original paper, published in 1882, Dr. Miller defines the sign as an inability to extend the leg fully when the thigh is at right angles to the trunk. Kernig's method was to set the patient on edge of bed and then try to extend the leg. He describes Osler's method of having patient on his back, then bring thigh to right angles to trunk and attempt to extend the leg on the thigh. This he thinks is the more satisfactory way, as we are enabled to more accurately determine the angle of extension, and even very sick patients are not inconvenienced.

In normal individuals the leg can be almost completely extended with the thigh at right angles to trunk. Kernig says that if the sign be positive the angle is about 135° and may reach 90°. He considered this an early and constant sign in meningitis, often remaining until convalesence was far along. His conclusions were based upon 15 cases of miningitis and confirmed in 8 autopsies. Of these 13 were cerebro-spinal, one tubercular and one suppurative. Kernig obtained the sign in spinal caries, pachymeningitis hemorrhagica, local meningitis from otitis media and chronic leptomeningitis. Dr. Miller refers to the many reports sence Kernig's paper, all confirming his observations.

Miller's cases were of several groups, acute infections, principally typhoid and pneumonia, the various forms of meningitis, central and peripheral, nervous diseases, convalescents from acute infectious diseases and surgical cases. The work was done at Cook County Hospital. The measurements were all made with an inclinometer, with patient in dorsal position. Dr. Miller took the angle of 115° for a positive Kernig, as better than the 135° of Kernig, since it excludes very few cases of meningitis and 135° is not infrequent in other conditions. He made a bilateral test in each case. Out of 190 cases of all groups he obtained a Kernig in 45. Four of ten cases of meningitis failed to give a reaction. These ten comprised a case of cerebro-spinal fever. (It must be rememberered that he used 115° as a standard against Kernig's 135°. H. M. R.) He states later that in only 2 cases of meningitis was there absolute absence of Kernig's sign and the diagnosis was confirmed in every case by lumbar puncture or autopsy. He states that in 7 out of 17 hemiplegics he obtained a positive Kernig (115° or less) and 4 others gave angles of 125° or less, the sign being bilateral in 4 cases. One was a hemorrhage into the ventricle; one a double hemiplegia with several weeks between attacks. The other two uncomplicated hemiplegias with no evidence to show ventricular or basal meningeal process. He reports 7 cases of syphilitic spastic paraplegia with 5 giving sign and 2 negative. One case of primary spastic paraplegia gave positive sign. He says he obtained a positive in 3 out of 16 cases of multiple neuritis, and 6 more gave an angle of from 120° to 125°. Two out of 12 sciaticas were positive. Two cases of uremia gave the sign. Three of 4 cases of cerebro-spinal syphilis gave positive, one entirely negative. Of the groups representing fractured thighs (3), pneumonia (22),typhoid (48),several gave the sign but had no other symptoms of meningitis.

Summary: (1) A maximum angle of 115° is better than 135°. (2) Measuring angle not essential, as some depend in part upon force used. (3) The sign is present in a large percentage of cases of meningitis; it is not constant, may appear late, may be transitory; daily examination should be made until found or not. (4) It is occasionally present in several very different conditions, showing lack of uniform cause for sign. (5) The sign is occasionally unilateral, exclusive of hemiplegia or local trouble, which might explain its unilateral presence. (6) The presence of the sign is a factor favoring the diagnosis in suspected cases of meningitis. Its absence must not be allowed to outweight positive findings. READ.

Epilepsy. By W. G. Spiller, M. D. Progressive Medicine, Vol. 6, No. 3.

In his review of the subject of epilepsy the writer quotes extensively from M. Allen Starr's article, in the Journal of Nervous and Mental Diseases for March, 1904. According to this review Starr regards it as an organic disease and bases his conclusions upon a study of 2,000 cases.

Rregarding Jacksonian epilepsy, Starr recognizes several types.

1st. A motor type with a characteristic local spasm of one or more parts upon one side of the body, followed by temporary weakness.

2d. A sensory type, with a sudden halucinatory perception in any one of the many senses, followed by a temporary suspension of the power of perception in that sense.

3d. An aphasic type, with a sudden interference in the function of speech either in the ability to understand or in the power to speak.

4th. A psychical type, with a dreamy state of the mind, or in which certain imperative ideas control the consciousness, arresting normal thought and often resulting in automatic acts, the object of which acts is not clear, and of which the person remembers nothing.

Starr thinks that it takes no argument to prove organic disease of the brain is the cause of Jacksonian epilepsy and what is true of Jacksonian epilepsy is equally true of the idiopathic form. When an aura occurs in the ordinary epilepsy it is always uniform in that patient.

The loss of consciousness which occurs in the ordinary form Starr says is due to the rapid extent and severity of the cerebral irritation and the resulting shock; that in severe Jacksonian epilepsy, consciousness is often lost.

He points out the fact that in ordinary epilepsy, organic changes in the brain are often overlooked; thus in two patients brought to him for nothing but epilepsy he found bilateral homonymous hemianopsia which had been congenital and neither patient knew they had defective vision. Both these cases revealed that they were borne after a hard labor with forceps. In both the epilepsy developed during the second year. READ.

BOOK REVIEWS.

Edited by
Kenelm Winslow, M. D.

Davis' Obstetrics. New (2d) Edition. A Treatise on Obstetrics. For Students and Practitioners. By Edward P. Davis, A. M. D., Professor of Obstetrics in Jefferson Medical College; Professor of Obstetrics and Pediatrics in the Philadelphia Polyclinic, etc. New (2d) edition, thoroughly revised and much enlarged. Octavo, 800 pages, with 274 engravings and 39 full-page plates in colors and monochrome. Cloth, $5.00, net; leather, $6.00, net. Lea Brothers & Co., Phila. and New York, 1904.

A handsome and well finished product of the book maker's art, a profusion of illustrations, many of them from original photographs and numerous colored plates, make the volume a most attractive one. The paper, type and printing are of first quality.

What first impresses the reader is the careful and scientific arrangement of the subject made by the author. He divides the book into six parts. Part I. embraces pregnancy and consists of twenty-four chapters, arranged in four sections. Part II. treats of labor, the birth canal, the fetus at term; comprises fifteen chapters under two sections. Part III. deals with the puerperal state and consists of nine chapters under two sections. Part IV. Obstetric surgery, in three sections, contains fifteen chapters. Part V. covers infancy in eleven chapters, under three sections. Part VI. The jurisprudence of obstetrics, is in five chapters.

The style is pleasing, the language simple, yet forceful and the expression clear and concise; and the author gives a most careful consideration to all details, so important to the successful practice of this branch of medicine. The chapter on fetal development is clearly written and beautifully illustrated; that on the pathologic conditions of the fetus is most excellent. The sections relating to the pathology of pregnancy and of the puerperal state are especially fine; while the chapters on the diseases of infancy and the jurisprudence of obstetrics are particularly interesting and add greatly to the value of the work. In dealing with position and presentation of the fetus the author prefers to use the German nomenclature on account of its simplicity.

The advantage of the use of the X-ray in determining the position of the fetus, as well as form of the pelvis, also in clearing up obscure conditions, is brought forward as a modern expedient in different diagnosis. Nothing seems to have been omitted, while unnecessary data and obsolete procedures are withheld. The technic is modern and most complete in all details. The author most justly condemns the freedom allowed midwives to practise their trade in this country,and says, "There is, however, no place for the practice of midwives in the United States, nor is there any reason whatsoever for their existence." And adds, "It would be a great misfortune to the American profession of Medicine should midwives be allowed to legally qualify for absolute practice."

The book is a most thorough, up-to-date and scientific work and highly commends itself to the general practitioner, the student and the specialist. LAZELLE.

Taylor on Genito-Urinary and Veneral Diseases and Syphilis. A Practical Treatise for Students and Practitioners. By Robert W. Taylor, A.M., M.D., Clinical Professor of Genito-Urinary Diseases in the College of Physicians and Surgeons, New York. New (3d) edition. Revised and enlarged. Octavo, 757 pages, with 163 illustrations and 39 plates in colors and monochrome. Cloth, $5.00; leather, $6.00; half morocco, $6.50, net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1904.

Taylor's work is too well known to require special introduction. That the second edition received translation into Italian is expressive of its popularity and highly complimentary to the author. This, the third edition, maintains the same conservative standard and approaches the advance of modern progress. Like many of the current text books on this subject this one volume is very comprehensive, including all diseases of the genital and urinary organs. This feature commends it as a compact and practical treatise for every day use, at the same time entailing brevity. It is unfortunate that American authors have not seen fit to enrich English medical literature by a complete reference work, such as von Frisch and Zuckerkandl's, Handbuch der Urologie. Our language is well supplied with compact treatises, of which Taylor's is a splendid example, but glaringly deficient in reference literature.

We note that two-thirds of this volume is devoted to genito-urinary diseases and the remainder to syphilis, a commendable arrangement. The opening chapters deal with gonorrhea and its complications, and includes a valuable description on urethritis in young boys. The chapters on diseases of the external genitals, bladder, kidneys, prostate, etc., are very satisfactory except in their cursory mention of surgical treatment. In fact the book is conspicuously poor in this regard. For instance only half a page is given to prostatectomy, with a short description of one method—Alexander's. On the other hand, the medical therapeusis is especially good.

It is in the second part of the book that this work particularly shines. Syphilis in its many manifestations is here described. The author does not hold, as some philologists, that syphilis is always a curable disease, although he states that, "We can tell our patients truthfully that two or two and a half years of careful, methodical, watchful treatment will be necessary, if they but conform to its regulations, sufficient to cure them." HAWLEY.

REPORT OF CONTAGIOUS DISEASES.

To the Washington State Board of Health for August, 1904.

Counties.	Smallpox		Scarlet Fever		Diphtheria		Typhoid Fever	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Adams	0	0	1	0	0	0	4	0
Asotin	0	0	0	0	0	0	1	0
Chehalis	0	0	0	0	3	0	0	0
Chelan	0	0	0	0	0	0	1	0
Clallam	0	0	0	0	0	0	1	0
Columbia	0	0	0	0	0	0	4	0
Douglas	0	0	0	0	5	0	0	0
Garfield	0	0	1	0	0	0	12	0
King	0	0	6	0	16	0	3	0
Kitsap	0	0	0	0	8	3	1	0
Kittitas	2	0	0	0	0	0	0	0
Lewis	0	0	3	0	0	0	3	0
Lincoln	4	0	0	0	8	0	4	0
Pierce	0	0	1	0	1	0	1	0
Skagit	0	0	0	0	0	0	2	1
Skamania	0	0	0	0	3	0	0	0
Snohomish	0	0	5	0	6	1	9	2
Spokane	1	0	0	0	4	2	3	0
Thurston	0	0	3	0	0	0	2	1
Walla Walla	0	0	0	0	0	0	30	2
Whitman	1	1	4	0	1	0	5	0
Yakima	0	0	0	0	3	0	19	0
Bellingham (city)	0	0	0	0	0	0	6	0
Seattle (city)	2	0	2	0	14	0	14	3
Spokane (city)	0	0	3	0	14	1	7	3
Tacoma	0	0	5	0	2	0	20	0
Total	10	1	35	0	88	7	152	12
August, 1903	34	2	53	0	21	5	87	19
Total 1904	270	7	824	36	768	104	425	75
Same period 1903	745	10	698	18	167	23		

The cases of smallpox reported in Whitman and Spokane counties both came from Idaho.

ELMER E. HEG, Secretary.

MEDICAL SOCIETIES.

Name. Meetings Held.

Washington State Medical Association.................1905—Tacoma
President, J. R. Yocum, M. D.; Secretary, A. H. Coe, M. D.

Chehalis County Society..1st Tuesday, Jan. Apr., July, Oct.—Aberdeen
President, D. A. Schumacher, M. D.; Secretary, J. W. Scamell, M. D.

Chelan County Medical Society..................................
President, W. M. McCoy, M. D.; Secretary, H. A. Saunders, M. D.

King County Society ....First and Third Monday—Seattle
President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

Lewis County Society ....First Monday
President, J. T. Coleman, M. D.; Secretary, Charles Harden, M. D.

Pacific County Society ....
............Third Monday of Jan., April, July, Oct.—South Bend
President, G. W. Overmeyer, M. D.; Secretary, Mary W. Gunwell, M. D.

Pierce County Society............First and Third Tuesday—Tacoma
President, C. Quevli, M. D., Secretary, A. de Y. Green, M. D.

Skagit County Society ....
President, A. C. Lewis, M. D.; Secretary, R. J. Cassel, M. D.

Snohomish County Society..................First Tuesday—Everett
President, C. A. Mead, M. D.; Secretary, James Chisholm, M. D.

Spokane County Society...................First Thursday—Spokane
President, G. S. Armstrong, M. D.; Secretary, Geo. A. Gray, M. D.

Walla Walla County Society.........Second Wednesday—Walla Walla
President, N. G. Blalock, M. D.; Secretary, Y. C. Blalock, M. D.

Whatcom County Society.................Second Monday—Whatcom
President, D. E. Biggs, M. D.; Secretary, W. N. Hunt, M. D.

Whitman County Socity.........Third Monday of Jan., Apr., July, Oct.
President, W. N. Divine, M. D.; Secretary, R. J. Skaife.

Yakima County Society.............First Tuesday—North Yakima
President, David Rosser, M. D.; Secretary, Carver, M. D.

Oregon State Medical Association ....1905—Portland
President, Geo. F. Wilson, M. D.; Secretary, L. H. Hamilton, M. D.

City and County Medical Society of Portland...First Wed.—Portland
President, R. L. Gillespie, M. D.; Secretary, A. D. Mackenzie, M. D.

Multnomah County Medical Society..........First Tuesday—Portland
President, A. Tilzer, M. D.; Secretary, L. Victoria Hampton, M. D.

Montana State Medical Association 1905
President, B. C. Brooke, M. D.; Secretary, Grace W. Cahoon, M. D.

Silver Bow Medical Society....Second and Fourth Wednesdays—Butte
President, T. J. Murray, M. D.; Secretary, Grace W. Cahoon, M. D.

Idaho State Medical Association............October 6 and 7—Lewiston
President, J. L. Conant, Jr.; Secretary, E. E. Maxey, M. D.

North Idaho District Medical Society..............June 9—Lewiston
President, C. L. Gritman, M. D.; Secretary, C. D. Parsons, M. D.

South Idaho District Medical Society.........Jan. 5, 1905—Pocatello
President, H. A. Castle, M. D.; Secretary, E. W. Kleinman, M. D.

British Columbia Medical Association...............1904—Vancouver
President, A. P. Procter, M. D.; Secretary, W. D. Brydone-Jack, M. D.

Vancouver Medical Society ....Vancouver
President, W. D. Brydone-Jack, M. D.; Secretary, J. S. Conklin, M. D.

Corrections and additions to this list are requested from societies reached by this journal.

NORTHWEST MEDICINE

November, 1904.

ORIGINAL CONTRIBUTIONS.

THE SURGICAL TREATMENT OF COMPLETE DESCENT OF THE UTERUS.*

By E. C. Dudley, M. D.

CHICAGO, ILL.

Complete descent of the uterus, descent to the third degree, which may be defined as that deviation in which a part or the whole of the uterus is outside of the vulva, is always associated with extensive injury to the pelvic fascia, the pelvic connective tissue, the muscles of the vaginal outlet, the perineum and the vaginal walls; in fact, these injuries of the pelvic floor constitute the essential lesion, the mal-location of the uterus being an incidental factor.

The uterus in its normal position lies across the pelvis, the fundus pointing in a slightly upward, anterior direction, and the external os in a slightly downward posterior direction. The long axis of the uterus in this normal direction makes an acute angle with the long axis of the vagina, which extends from the vulva upwards and backward, in the direction of the hollow of the sacrum. Generally speaking, mobile anteversion, with some degree of anteflection, is the normal position of the uterus; at any rate, the uterus in its normal range of movements does not deviate, unless temporarily, beyond the limits of a certain normal anteversion and anteflection.

In the etiology and treatment of descent the practical significance of this acute angle between the axis of the uterus and vagina is very great because the uterus in the act of prolopse must descend through the vaginal canal in the direction of that canal, that is, a coincidence of the two axes is a prerequisite to descent. Now, if the essential condition of descent is a coincidence of the axes, it follows that one factor at least in the treat-

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*Read before the Canadian Medical Association, Vancouver, B. C., Aug. 23—26, 1904 (By courtesy of the *Dominion Medical Monthly*).

ment of descent must be to restore the normal angle between the axes.

In labor the anterior wall of the vagina is so depressed, stretched and shortened by the advancing child that, during and after the second stage, the anterior lip of the cervix uteri may be seen behind the urethra. This location of the cervix—so close to the anterior wall of the pelvis—necessarily involves great stretching of the utero-sacral supports which normally hold the cervix uteri, and together with it the upper extremity of the vagina, close to the hollow of the sacrum. This function of the post-uterine ligaments having been temporarily impaired, the upper extremity of the vagina is displaced forward, so that the uterus, having sufficient space between itself and the sacrum, instead of maintaining its normal anterior position, may fall backward into retroversion and thereby bring its own axis into line with the direction of the vagina. Frequently the change in the direction of the vagina from the normal oblique to the abnormal vertical is still further increased by injury to the vaginal outlet: the perineum may be torn in any direction and, what is more serious, it may be torn away from its pubic attachments and in this way may be displaced backwards towards the tip of the coccyx. In fact, such displacement is so common as the result of injuries to the perineum as to suggest the propriety of a change in terminology from laceration to displacement of the perineum. The upward extremity of the vagina being displaced forward and the lower extremity backward and the direction of the over-stretched, dilated vagina now being vertical, the heavy uterus, having its long axis in the same vertical direction, has all the conditions favorable to progressive descent.

If the puerperium progress favorably with prompt involution of the pelvic organs and if the relaxed vesico-vaginal wall and other parts of the pelvic floor, especially the utero-sacral supports and the broad and round ligaments, recover their normal tone, then the whole pelvic floor, including the uterus, resumes its normal relations. But if the enlarged heavy uterus remain in the long axis of the vagina: and especially if the fundus uteri be incarcerated under the promontory of the sacram with the sacral supports stretched so much and for so long a time that they cannot recover their contractile power: and if normal involution of the pelvic organs be arrested, then descent may not only persist but may progress with constantly increasing cystocele and rectocele until the entire uterus has extruded through the vulva.

It is most important to remember that complete prolapse of the uterus is only an incident to prolapse of the pelvic floor. The whole mechanism is that of hernia and the condition is hernia for the extruded hernial mass drags after it a peritoneal sac which, hernia-like, contains small intestine. This sac forces its way to the pelvic outlet and extrudes through the valva, having the inverted vagina for a covering.

The prolapsing uterus may be related to the vaginal walls in either one of two ways: The prolapsing vaginal walls may drag the uterus down after it; or the uterus itself may descend along the vaginal canal by force of its own weight and drag with it the reduplicated walls. Extreme prolapse of the uterus, the organ being covered thus by reflected vaginal walls, has given rise to considerable confusion in pathology and by many standard authors has been wrongly called hypertrophic elongation of the cervix uteri. In a given case, the possibility of infra-vaginal elongation may be settled easily by placing the patient in the knee-breast position, when the uterus of its own weight will fall toward the diaphragm and the reduplicated vaginal walls will unfold and utero-vaginal attachment will appear in the normal place instead of being, as it seemed to be, high up on the walls of the uterus. Those cases in which reduplication of the vaginal walls does not almost entirely explain apparent great elongation of the cervix, are rare exceptions. When formerly these mechanical conditions were attributed to hypertrophic enlargement of the uterus itself and were regarded as adequate indications for the removal of the cervix, the surgeon, in the attempt to remove what he supposed was the elongated cervix uteri, sometimes invaded the bladder anteriorly and the rectum posteriorly.

Surgical Treatment.

In passing it may be well for the purpose of condemning it, to mention an operation perhaps, more frequently performed than any other for the cure of complete descent, namely, the operation which generally passes under the name of Stoltz. This operation is designed to narrow the vagina and thus to maintain the uterus somewhere in the pelvis above the constriction. Operations of this class usually consist of the removal of an elliptical piece from the anterior or posterior vaginal wall or from both and of closing the exposed surface by means of a pursestring suture. No effort is made to restore the normal axis of the uterus and vagina. The whole purpose is to make the vagina so narrow that the uterus cannot pass through it. Such operations generally fail because they leave the uterus and vagina in the same axis and because the restricted vagina cannot resist the downward force of the uterus, which almost invariably dilates the vagina a second time and forces its way through with reproduction of the hernia. Moreover, the operation always does permanent harm because it shortens the vagina, thereby making it draw the cervix away from the sacrum towards the pubes so that the body of the uterus may have room to fall backward to the position of incurable retroversion. We may without discussion, perhaps, throw out all operations belonging to the Stoltz group. The same may be said of all plastic operations in which the vaginal surfaces are exposed by superficial denudation and brought together by sutures.

After a prolonged trial of the principal surgical procedures which have been made use of for the cure of complete descent, I am prepared to lay down certain essential principles as follows:

An efficient operation on the vaginal walls should have for its object, not narrowing the vagina, but restoring the normal direction of it with a double purpose, so that, (a), the upper extremity together with the cervix uteri shall be in its normal location within an inch of the second and third sacral vertebras, just where the utero-sacral ligaments would hold it if their normal tonicity and integrity could be restored; and so that, (b), the lower extremity of the vagina shall be brought forward against the pubes. The fulfillment of these two indications will restore the normal obliquity of the vagina and will hold the cervix uteri so far back toward the sacrum that the corpus uteri must be directed forward in its normal anterior position of mobile equilibrium. With these conditions, the uterus being at an acute angle with the vagina and having little space posteriorly, cannot retrovert and turn the necessary corner which would permit it to prolapse in the direction of the vaginal outlet. In order to accomplish this two things usually are necessary:

1. Excision of the Cystocele.

Anterior Colporrhaphy. The plastic operations performed on the anterior and lateral walls of the vagina by Sims, Emmet, myself and others, which have consisted of superficial denudation and reefing of the anterior or lateral walls of the vagina have been only partially successful, first, because they did not adequately force the cervix uteri into the hollow of the sacrum; second, because efficiency requires deeper work than superficial denudation can accomplish and third, because these operations did not utilize the broad ligaments sufficiently for support.

The above principles, emphasized by Reynolds in a recent paper, have lead me to modify my own operation materially. Complete prolapse, being hernia, should be treated according to the established principles of herniotomy by reducing it and then excising the sac in such a way as to expose strong facial edges which should be firmly united by sutures. The absurdity of treating any other hernia by superficial denudation and reefing or tucking in the surfaces by sewing them together must be apparent to any one. In order to indicate the part which the broad ligaments must have in a correct operation it is only necessary to observe the fact that vaginal hysterectomy commonly results in holding up the pelvic floor and with it the rectum, vagina and bladder because in this operation the broad ligaments are usually fixed to the vaginal wound. But why should not the same result be aimed at by similar means even though the uterus is not removed? The operation which I would urge is performed as follows:

Anterior Colporrhaphy.

First Step.—To split the antero-vaginal wall—that is, the vaginal plate of the vesico-vaginal septum—by means of scissors, from the cervix uteri to the neck of the bladder, then to strip off the vaginal from the vesical layer of the vesico-vaginal wall and cut away the redundant part of the vaginal plate.

Second Step.—The redundant part of the vaginal wall having been removed, to extend the incisions and remove the mucous and submucous structures to either side of the uterus, being sure to reach the facial structures, which are in direct connection with the lower margins of the broad ligaments or, what is better, to reach the ligaments themselves.

Third Step.—To introduce silk worm gut or chromic catgut sutures so that when tied they will draw the loose vaginal tissues and the broad ligaments structures on either side of the cervix uteri in front of the cervix so as to force the cervix back into the hollow of the sacrum.

Fourth Step.—The sutures introduced in the third step having been tied, additional interrupted sutures are introduced to unite the vaginal wound from side to side; this suturing is continued to a point near the urethra, when most of the redundant vaginal wall will have been taken up; there will usually remain, however, the lower portion of the cystocele and perhaps some urethrocele, which cannot be disposed of by bringing the margins of the wound together from side to side, but can be taken up by uniting the remaining part of the wound in a transverse direction.

Even at the risk of prolixity I repeat that it is essential to remove the entire thickness of the vaginal layer of the vesico-vaginal septum.

Contraindications to Elytrorrhaphy—Elytrorrhaphy is usually unnecessary and therefore contraindicated in descent of the first degree. The special province of the operation is in complete prolapse or procidentia when associated with cystocele. The operation, further, is contraindicated by tumors and adhesions which render replacement and retention impossible, and in diseases of the uterus or its appendages which demand their removal. When such contraindications do not exist, elytrorrhaphy and perineorrhaphy, in a majority of cases, are quite as effective and therefore to be preferred to the more dangerous and mutilating operations of hysterectomy.

2. PERINEORRHAPHY AND POSTERIOR COLPORRHAPHY.

As already stated, it is most important to appreciate the fact that in nearly every case of procidentia the lower extremity of the vagina is displaced backward. This is consequent upon subinvolution of the pelvic floor and especially upon subinvolution or rupture of the perineum or of some other portion of the vaginal outlet. Unless, therefore, the posterior wall of the vagina and the perineum can be brought forward to their normal location under the pubes, so as to give support to the anterior vaginal wall, the latter will fall again, will drag the uterus after it, and the hernial protrusion (cystocele and prolapse) will be reproduced. The treatment, therefore, of procidentia must always include an adequate operation on the perineum, or, more comprehensively speaking, upon the posterior wall of the vaginal outlet. The operation must be performed so that it will carry the lower extremity of the vagina forward to the normal location close under the pubes; then, if the anterior colporrhaphy has been adequate and has carried the upper extremity backward, the whole vagina will have its normal oblique direction, and its long axis will make the necessary acute angle to the long axis of the uterus.

HYSTERECTOMY.

Hysterectomy, if indicated, should be performed by the vaginal route. As an operation for procidentia hysterectomy is open to the following comments: Procidentia, as already shown, is hernial descent, not merely of the uterus, but also of the vaginia, bladder and rectum. Complete prolapse often occurs after the menopause, when the uterus has become an insignificant rudimentary organ, and therefore may be removed easily. Cases are numerous in which, after vaginal hysterectomy, the pelvic floor and with it the vaginal walls, have protruded again through the vulva—a result which may be expected unless the operation has included anchorage of the upper end of the vagina to its normal location by stitching the severed ends of the broad ligaments into the wound made by removal of the uterus. The indications for perineorrhaphy as a supplement to hysterectomy is the same as after anterior colporrhaphy.

As laid down in the foregoing paragraphs, the utilization of the broad ligaments is the essential factor in the treatment of complete procidentia. The operation of elytrorrhaphy above described unfortunately either may fail to bring the lower edges of the broad ligaments sufficiently in front of the uterus to enable them to hold up the uterus and vagina or the ligaments, having been stitched in front, the stitches may not hold. Consequently, in complete procidentia, elytrorrhaphy even though well performed may fail; at least, this has been my experience in a number of cases. Therefore, the completely prolapsed uterus may have to be removed in order to secure the entire outer ends of the broad ligaments to the upper part of the vagina, and thereby give absolute support. As before stated, the operation should include the treatment of the hernial factor in the lesion, that is, removal of the redundant portion of the anterior vaginal wall. Generally speaking, the indications are somewhat as follows:

1. Extreme cystocele not associated with the most extreme procidentia should be treated by anterior colporrhaphy and perineorrhaphy.

2. Cystocele associated with complete procidentia properly may be treated by hysterectomy, anterior colporrhaphy and perineorrhaphy. Anterior colporrhaphy in all cases.

3. Conditions intermediate between the two conditions indicated above and cases of very feeble or very aged women will call for special judgment whether hysterectomy be omitted or performed. It is, however, a fortunate fact that the completely prolapsed uterus, even in aged women, is removed usually with ease and with safety.

HELPS AND HINDRANCES TO PROPER PRE-NATAL CONDITIONS.*

By W. C. Hastings, M. D.
Seattle, Wash.

It is not my hope that I shall offer anything new on the above important and interesting subject, but that I may call out, by presenting some of the established phenomena influencing the child before birth, a discussion of the subject by the members of this society, that will be of utility to all, in that we can the better point out to those seeking our advice the things to avoid and the helps to use, so that their children may be physically and mentally healthy.

If the child foreshadows what the man will be, so much more is the fetus in utero the epitome of all that it will be; for what is begun there will continue to grow through all the future. Surely the crowning fortune of a man is to be born with such a disposition that whatever pursuit he may follow it will find him in employment and happiness, whether it be to make baskets or broadswords, canals or railroads, statutes or songs.

Among men the merest trifles, cheerfulness, tact, quickness of observation, have helped to success; or, on the contrary, little failings, foibles and weaknesses have tended to their failure. Of these nothing conduces to a man's happiness so much or influences his career in life as his disposition. "A propensity to hope and joy is real riches; one to fear and sorrow real poverty."

Two men have the same intellectual powers, the same virtues, the same skill and experience; the one is cheerful, healthy in mind, enthusiastic, affectionate; the other morbid, lethargic and self-deprecating. It is not difficult to tell which becomes a power in the world and which the dead weight. Today, as well as in the past history, it is pitiful to note the under-estimation of certain men regarding themselves, who are obscure for want of courage.

Why are men endowed by so greatly diverse dispositions? Disposition has been defined as the "unconscious tendency of the whole nature." What causes these different tendencies in individuals but the transmission of such qualities from the parents?

At the outset the influence of the father is no doubt as great as that of the mother, making them equal in responsibility. Therefore it is incumbent upon the father, as much as the mother, that he does not reproduce his own drunkenness or transmit his own syphilitic taint or any other dyscrasia to his children. But not until it is recognised that the responsibility of the father is co-equal with that of the mother, no difference how noble, how pure, how perfect the mother's life may be, can we expect physical and moral excellence in the child.

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*Read before the Washington State Medical Association, Seattle, Wash., July 12, 13 and 14, 1904.

But subsequently, if the mother be fretful, complaining and exacting, neuropathic, thinking of self alone, what else can we expect but a selfish character in the child, and that it will develop into a selfish man? "A man that works for self alone works for a very small man."

What beside causes the throngs of deaf, blind, crippled, idiotic unfortunates who are "born so," together with a still larger class of neuropathic, psychopathic, mentally and physically weak individuals?

These questions have been ably and beautifully answered by Dr. J. D. Buck in his, "Study of Man," a book well worth the diligent perusal of every thinking man. Dr. Buck says, speaking on the same subject, that, "All future growth is but a continuation of processes already begun. No principle can be discovered in the life of man that has not here its root and rise. The dawn of consciousness, the growth of intelligence, the manifestation of life through co-ordinate rhythm establishing the equilibrium we call health, all these have their potency and prophecy in the vivified germ. Millions of times this miracle is repeated, yet millions regard it with indifference. Accident, caprice or blind lust determines it ten thousand times where love and wise forethought provide for it but once. Nativities are saturated with murder and marked by paternal thoughts that are crimes. Little helpless souls are thus scarred all over, and evil destinies are thus heaped upon them from their very birth. Oh, horrible reproach on the divine office of parentage.

* * * * * *

"There is but one single cause for all this misery of human life, and it can be spoken in one word, egotism. It arises from ingrained selfishness derived from the animal in man, forgetting all good for the sake of self. * * * Human beings are not fit to be parents till they are morally of age, and as being is before knowing and doing, I affirm that education can never repair the defects of birth. * * * There is no subject that lies so near the cause of all human ills, and that is so potent a factor in the regeneration of the human race as the condition of parentage and the influence of so-called heredity, or natal and ante-natal conditions."

For a familiar example of hereditary predisposition to disease we have only to refer to the effects of habitual alcoholic excess, which not only tends to insanity in the subject of it, but often expresses itself in the offspring in idiocy, epilepsy, alcoholic craving, mental instability, weakness of will, uncontrollable hysteria and the like, as well as insanity. The same may be said of other abnormal moral habits, as we see in hereditary kleptomania and perverse sensuality.

Owing to the predominating nervousness of modern social life, children are born defective. They develop into neuropathic, psychopathic, sensual individuals, liable to commit perverse acts sexually and otherwise. Inasmuch as the preservation of chastity and morals is one of the most important reasons for the existence of the commonwealth the state cannot be too careful as a protector of morality in the struggle against sensuality. Yet criminal statistics prove the sad fact that sexual crimes are progressively increasing in our modern civilization; and, moreover, only a small number of such crimes can be legally combated.

While legal enactments are necessary, yet far better let it be impressed upon parents to keep themselves bodily and mentally healthy, and maintain purity of heart and life at all times. If parents would stop and consider all this and then act upon it, what a great source of crime would be thus cut off.

Of course the influence of "six thousand years of transgression cannot be effaced in a single generation," but persevering effort along this line would show remarkable results in a few decades in a general advancement of the human family, both in intellectual endowments and physical beauty. These laws have been carefully studied and applied in the production and development of domestic animals. So it is no new law we advocate, but simply a new application of an old law of nature to the human race.

It is true that the fetus in utero is physically, as far as we can discover, beyond the control of the mother; and that there is no way by which impressions made on the mother's mind can be physiologically conveyed by nerves to a particular part of the fetus, so as to affect its growth or development. But the multitude of facts which have accumulated has led physiologists to admit and believe that maternal emotions may affect the proper development and adjustment of the parts of that complex and delicate organ, the brain, in certain directions. Thus peculiar idiosyncracies and predispositions to insanity arise, and indirectly deformity and arrest of the proper development of the child results.

When we consider the consequences of fear or joy, of grief and sorrow, of nostalgia, of mortification upon the nervous system and indirectly upon the different organs of the body—as by them the liver has been deranged, causing jaundice; heart's action accelerated or suspended; kidneys stimulated, causing diuresis; or intestinal follicles stimulated, causing watery evacuations; likewise the gravid uterus, causing miscarriage—need we ask that the environments of pregnant women should be such as conduce to cheerfulness and equanimity?

What greater calamity to an unborn child than that which we too often see in the young wife or unmarried woman who, oppressed by a vague fear of death or of wrong committed, instead of looking forward with joy to a happy future, is depressed, and perhaps cherishing thoughts of murder and hate against the little heart that beats beneath her own. Unwelcome children! Is it strange that there are so many Ishmaelites in the world: their hands against every man, and every man's hand against them?

In like manner the parents' self-indulgences and peculiarities of temperament may be intensified as mental or moral degeneration in their children, producing a large class of persons predisposed to drunkenness, insanity, crime and all kinds of moral perversions. For this large class of persons whose particular propensities, though undoubtedly aggravated by vicious training, are inherited, physicians have only compassion, considering them to be invalids, although they are treated by law and society as responsible.

When we reflect on the many dangers to which children from the earliest period of their existence are liable, and by which so large a proportion of them are annually destroyed, and consider also that these dangers might easily be avoided, the physician can scarcely be considered as fulfilling all his duties when he neglects to point out and urge the administration of such means as to prevent such disastrous results.

Whatever conduces to the health of the mother conduces to the growth and development of the fetus. Therefore, let her diet be plain and easily digested, but nutritious. Let her daily exercise be moderate and gentle, never violent, as lifting heavy weights, or any exercise whereby the abdominal muscles would be called into great and continued action. Let her not only avoid any excessive physical exertion, but likewise undue mental excitement.

Let any disease she may have, have appropriate treatment, so that any effects that it ight have may be reduced to minimum, otherwise it will retard fetal development. Even if the father alone seems to be the only one affected with a constitutional vice, as alcoholism, syphilis, or pulmonary phthisis, his offspring often shows signs of imperfect development, although the mother's condition of health be good. Even here such treatment should be adopted as will conduce to the proper development and nourishment of the fetus.

In syphilis being present in the fetus and new-born we have conclusive evidence, even if there were no other, that intra-uterine transmission of disease is a possibility. Also while the intra-uterine development of rachitis is of comparitively rare occurrence, yet that it is possible, is established by the anatomic and anatomico-pathologic lesions in the bones of new-born infants. It has likewise been demonstrated that the typhoid germ as well as the bacillus anthracis is capable of penetrating the placenta and passing from mother to the child. Children have been born with measles, scarlet fever, smallpox, erysipelas, etc. The danger to mother and child in these cases is very great. If this be the conclusion in reference to morbific germs, so may appropriate agents act on the child through the mother so as to correct anatomic and structural deficiencies. As important as nutritious food and good hygienic environment are for keeping the mother's system in health, yet of equal importance is proper medication when her health becomes deranged.

We will now turn out attention and consider three of the prenatal diseases that can be influenced to a considerable extent by proper treatment.

1. Tuberculosis.—The subject of tuberculosis is probably receiving today greater attention than any other disease. Every practitioner has had healthy children born of tubercular parents and moreover the theory that tuberculosis is not properly hereditary is the one that has the most adherents at the present time. Yet it is a well established fact that the offspring of tubercular parents are more likely to lack the necessary power of resistance against the invasion of the tubercle bacilli than those of non-tubercular parentage. Hence for this reason the marriage of tubercular individuals should be discouraged. But if conception has taken place, the appropriate treatment of the mother, mentally, hygienically, and medicinally will have a beneficial effect in giving the child a greater power of resistance.

2. Syphilis.—The treatment of hereditary syphilis consists in the prophylactic treatment of the parents before conception and the treatment of the mother during pregnancy.

Probably the most important point in prophylaxis is that the earliest period at which marriage should take place should be four years after infection, during which time proper treatment should be followed. However, if that rule be disregarded and pregnancy results, it becomes imperative to treat the mother and so indirectly the child. We have in mercury and potassium iodide the appropriate remedies, special care being exercised not to allow the medication to produce gastro-intestinal irritation since this would strongly predispose to the production of abortion. When the mother is thus treated the probability is that the child will be healthy or at least only exhibiting syphilis in a mild form.

3. Rachitis.—Of fetal diseases of the bones rachitis is the most prominent and consequently it is the duty of the family physician, when rickety children have been born, to immediately institute appropriate treatment in case the mother again becomes pregnant.

In as much as it is impossible to diagnose a disease of the fetus except after birth or by post-mortem examination, the physician, in order to successfully treat a suspected disease of the fetus must be acquainted with the family history, not only of the mother but also of the father. Likewise the health and general condition of previous children must be taken into consideration.

Prof. Chas. Gilmore Kerley, in an article on "The Demands of the Child by Virtue of Right", read before the American Medical Association, at Atlantic City last month (Journ. A. M. A., July 9, 1904), says, "If success in life, happiness and usefulness depend to so great a degree on a normal body, surely the child has a right to demand sufficient consideration that this may be furnished. It is known to all that mental and physical degeneracy go hand in hand. That a sound mind requires a sound body is a maxim that will be disputed by none who have had to do with children."

Accordingly, is it not our highest duty as physicians to elevate the physical and to assist the moral condition of mankind: to see that sunshine and not gloom is brought into the world? Proper pre-natal treatment will assist in the successful accomplishment of this end. Even as disease may be communicated to the fetus so are we able to apply curative measures. Improve both the physical and mental conditions of the mother and that of the unborn child will be improved. Let the mother be cheerful, happy, and contented, and her children will be an honor and a glory to the nation.

DIAGNOSIS OF DISEASES OF THE SKIN.*

By Robert W. Schoenle, M. D.,
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The difficulty of all specialists who read papers before meetings of medical men, who are not subdivided into sections, is to find a subject of interest to the general practitioner. In choosing for my subject Diagnosis of Diseases of the Skin, I trust I have met this prime requisite.

It is needless to say that without the ability to make an accurate diagnosis in cutaneous diseases the management of the case in hand is haphazard, unscientific and culpable.

Perhaps in dermatology more than in any other branch of medicine, a correct diagnosis is entirely dependent upon the ability of the observer to appreciate minute details, and to so group these oftentimes slight premises that their logic is irresistible. In dermatology the eye and the touch form our principal means of diagnosis, and correct conclusions do not depend so much upon the skilled use of specially devised instruments as upon shrewdness and soundness of judgment. Aside from the eye and the touch, a good light and a good microscope are required for diagnosis. The first three are essential, the last in many instances supplementary, but in some cases, as in determining the nature of tumors and growths, in detecting the presence of parasites, it is indispensable. In fact, it is of great value in studying pathologic processes cannot be too highly appreciated.

A certain method is necessary in conducting the investigation. The patient should always be placed in a good light, and it is essential in most cases that it should be daylight: so much is color, especially if at all yellow, modified by artificial light that, unless this is unusually white, eruptions of a faint yellow may be overlooked altogether. Julien recommends a cobalt blue glass as an aid in the early recognition of secondary syphilis.

Completeness of Examination.—The whole eruption should always be seen, if possible, as a perfectly erroneous idea may be conveyed by merely seeing the part presented by the patient, which is selected either because it gives the most annoyance or is the most easy of access, while the most typical features of the rash are perhaps only to be found elsewhere.

In men and children there is no difficulty, as they can always be stripped, if the room is properly warmed, an essential condition for, if it be too cold capillary congestion of the skin may occur, causing a mottling which is very confusing; while in women, one has often to be satisfied by seeing the eruption by installments; but where there is any doubt, this at least should be insisted on, as the patient would be first to blame the doctor if an error arose from imperfect examination; at the same time, the subject must be led up to with gentleness and tact, after preliminary conversation has put her at ease.

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On first seeing a patient, the sex, apparent age, general conformation, complexion and aspect are noted. While most dermatologists pride themselves on making a diagnosis alone by the appearance of the lesion or lesions, respectively, it is safer and easier to ask the patient certain questions, the information elicited being duly weighed and measured by the knowledge and experience of the physician. How long have you had it? is the first and most important. It often clears the ground of so much, and will, in many cases, be decisive as to the nature of the disease. Thus, in a widespread erythematous eruption, a duration of two or three weeks would at once exclude all exanthemata for which it might be mistaken, or, in an infiltration, a duration of several years, with very slow extension, would point to lupus, rather than syphilis.

The next question is: What was the course? A large number of eruptions develop in a characteristic way, and alter considerably from their first appearance. This is essentially the case in erythema multiforme, in many cases of eczema, in urticaria papulosa, etc.

An eruption is often modified by various circumstances beside time, such as scratching, poulticing, or previous treatment by another practitioner. Then the eruption may come out all at once, as in herpes, or in successive crops, as in pemphigus and varicella, or by continuous or intermittent spreading, as in pityraisis rubra, and in many cases of eczema; or some lesions will be coming and others fading, as in secondary syphilis and hydroa; or again, there may be constant recurrences just when the disease appears to be cured, as occurs commonly in eczema.

The third question is: What symptoms, especially as regards itching, fever, etc., attended or preceded the eruption?

The fourth question: What is its cause? has to be answered, as a rule, by the physician himself, after eliciting from the patient, by question and physical examination, the various external and internal conditions antecedent to the outbreak. Age, sex, social condition and occupation also come in here for consideration. Whether the eruption is only part of a general disorder, or is a disease of the skin itself, will often be decided by the presence and nature of the constitutional symptoms.

We next ascertain how much of the surface is involved, and what regions are especially affected. The importance of noting the distribution cannot be too much insisted upon. Some skin affections, as the eruptive fevers, attack the entire surface, while in others only a limited portion is affected, as in lupus, epithelioma, etc. The eruption may be symmetrical, as in lupus erythematosus; unsymmetrical, as in lupus vulgaris: unilateral, as in herpes zoster and morphea: irregular and disseminate, as in scabies and parasitic diseases generally. Then, is the lesion single, as in rodent ulcer: or multiple, as in most eruptions? Is it of uniform character, as in scarlatina form eruptions, or multiform, as in syphilis, scabies, eczema, erythema multiforme? Investigating still more closely, is there any definite arrangement of the individual lesions, either in groups in the course of a nerve, as in herpes zoster: or in circles or segments of circles, as in tinea circinata, etc.? Especially in syphilis is the grouping of the lesions an important feature. Furthermore, many eruptions manifest a predilection for certain regions, which they are found occupying with considerable constancy. The following table by Pye Smith somewhat modified, illustrates this relation. In this table the regions are mentioned, with the diseases which are most apt to be encountered occupying them.

Scalp: Eczema, seborrhoea, alopacia, alopecia areata, psoriasis, syphilis, steatoma, favus, ringworm (in children), pediculosis.

Face—Forehead: Chloasma, syphilis, psoriasis, acne, zoster, epithelioma. Eyebrows: Seborrhoea, alopecia areata, alopecia syphilitica. Eyelids: Xanthoma, milium, eczema tarsi. Nose and Lupus, epithelioma, rhinoscleroma, rosacea, seborrhoea. Nose and Cheeks: Rosacea, lupus erythematosus. Nostril orifice: Folliculitis, impetigo, herpes. Upper lip: Eczema, herpes, lupus. Lower lip: Epithelioma, syphilis. Mucous membrane of mouth: Herpes, syphilis, measles, smallpox, leucoplakia, lupus, lichen planus, pemphigus. Bearded face: Sycosis, pustular eczema.

Ears: Lupus erythematosus, lepra, xanthoma tuberosum, syphilis, eczema.

Neck: Scarlatina, eczema, intertrigo, furuncle, carbuncle, sycosis.

Back: Acne, tinea versicolor, pediculosis, seborrhoea, carbuncle.

Chest: Scarlatina, varicella, syphilis, seborrhoea, keloid, lenticular cancer. Breasts: Eczema, keloid.

Nipple: Scabies, eczema, Paget's disease.

Sides of Trunk: Zoster, syphilis.

Abdomen: Typhoid and typhus rashes, tinea versicolor, syphilis, scabies. Umbilicus: Scabies, carcinoma, erysipelas.

Scrotum: Eczema, pruritus, syphilis, elephantiasis.

Prepuce: Scabies, herpes, syphilis, chancroid, eczema.

Nates: Furuncle, carbuncle, scabies, syphilis.

Anus: Eczema, pruritus, mucous tubercles.

Elbows—Flexor side: Eczema, xanthoma planum. Extensor side: Psoriasis, ichthyosis, xanthoma tuberosum.

Forearms and backs of hands: Erythema multiforme.

Wrists—Flexor side: Scabies, lichen planus. Extensor side: Smallpox.

Hands and Feet: Eczema, scabies, callosites. Palms and soles: Eczema, syphilis, pompholyx. Fingers and toes: Chilblains, pompholyx. Nails: Hypertrophy, onychomycosis, onychia, paronychia, atrophy.

Axilla and groins: Eczema, intertrigo, ringworm, erythrasma.

Thighs—Extensor side: Prurigo, keratosis pilaris.

Knees—Extensor side: Psoriasis, ichthyosis. Flexor side: Eczema.

Legs: Eczema, elephantiasis, ulcers, erythema nodosum, purpura, ecthyma.

Universal: Eczema, psoriasis, ichthyosis, erythema scarlatini, noids, dermatitis exfoliativa, pitiryasis rubra, lichen acumenatus.

One of the most important guides to diagnosis is afforded by the color of the eruption. The peculiar brownish red of syphilis is very different from the bright red of psoriasis; the light brown color of tinea versicolor, the yellow of favus, the translucent brown of lupus nodules, the varying shades of herpes iris, are all more or less characteristic. Not only does the color aid in distinguishing the various diseases, but from it we may often draw an inference as to the acute or chronic nature of the malady. In long-standing inflammations brown or yellow pigmentary deposits are often present, while about an effusion of blood, which has existed for some time the play of colors so characteristic of a bruise may be noted.

The odor eminating from an affection of the skin will sometimes give a clew to diagnosis. Favus smells like a mouse's nest, while the characteristic smell of gangrene is well known.

The individual lesion itself has now to be examined. Is it a primary lesion, such as a macula, an erythema, a papule, nodule, tumor, or infiltration, vesicle, bulla, pustule, or wheal, or some special lesion, as a wart, horn or burrow; or is it a secondary lesion, and therefore scaly, scabby or crusted, excoriated from scratching, or otherwise fissured, ulcerated, scarred or stained? Then, its pathologic nature must be determined. Is it due to congestion, inflammation, hemorrhage, hypertrophy, atropy, a neoplasm or a parasite, either animal or vegetable?

Stelwagon, in his latest edition of diseases of the skin, has elaborately tabulated the different more common skin diseases according to the primary lesions, adding the size of the lesions, region and other characters and features calculated to be of some additional aid. Time and space forbid me from giving this valuable tabulation, which, however, I recommend for your perusal.

Finally, the general condition of the skin must be noted, whether it is dry or moist, greasy, rough, etc.

The various secondary lesions have often a direct bearing upon diagnosis. The scaling of psoriasis is one of its most marked features; an oozing eczema is sure to be heavily crusted; gummata readily break down, leaving punched out ulcers; late syphilids leave thin flexible scars in the center, while the periphery still spreads; in lupus, on the contrary, the scars are thick, adherent, and traversed by bands or cords. Scratch-marks are a sure indication of the itching nature of a disease, and are of great importance in diagnosis.

The microscope, as a valuable aid to diagnosis, has already been alluded to.

Chemistry as directly applied has not been of much service to dermatologic diagnosis, but a careful examination of the urine should never be omitted, as in this way we may often discover a Bright's disease or a diabetes lying back of a furunculosis or an eczema of the genitals.

In conclusion, let me say that this paper makes no claim to completeness, but is intended to serve only as a stimulus and as a plea for an accurate diagnosis of diseases of the skin.

CLINICAL REPORT.

REPORT OF A CASE OF HEMORRHAGE INTO AN OVARIAN CYST.*

By Geo. W. Libby, M. D.

SPOKANE, WASH.

On May 18 I was called to Mrs. D. L. C., age 48, medium height, slight build, mother of one child, age 9 years. Patient gave following history. Always in good health, her labor was normal, no miss-carriages. Menstruation has been regular and normal; the last began 12 hours before my visit. On the 15th, three days before, she was taken with severe abdominal pain, vomited; pain first felt on left side of abdomen. On the night of the 17th, when menstruation began, pain subsided in a degree but returned during the night; pulse 80, very weak; temperature 99.5°; countenance anxious; evidence of great abdominal pain; abdomen tympanitic except over pubic, left iliac and left lumbar regions; liver dullness obliterated. A hard mass was distinctly outlined in left side of abdomen, from iliac region to costal margin, with anterior border 2½ inches to the left of the umbilicus.

That the woman was having hemorrhage was evident, that there was some association between the hemorrhage and the mass in the abdominal cavity seemed probable. My theory was tubal pregnancy with rupture, hemorrhage confined by adhesion to produce the local tumor, a theory rather far fetched to account for the conditions. Operation was advised but positively declined. I requested Dr. Armstrong to examine the case and give his opinion to the family, he having no knowledge of my diagnosis. His examination was made two hours later, at which time tympany had so increased that the tumor could not be outlined and patient growing weaker. He thought tubal pregnancy with rupture probable, and advised immediate operation which was still refused by the patient. Two hours after Dr. Armstrong's visit I saw the case again and found the patient rapidly approaching collapse, patient and friends desirous that an operation be done at once. Patient not being in condition to be moved to the hospital, preparations for operation at home were hastily made.

Operation at 4 P. M., Drs. Armstrong and Tooker assisting. I removed a left monolocular ovarian cyst, eight by six inches in dimensions, blackened and distended by infiltration of blood into its wall, the broad ligament which formed the pedicle also infiltrated, three-fourths of an inch in thickness, left tube extending across lower aspect of the tumor thickened and embedded in cyst wall, remains of left ovary merged in the cyst wall. The cyst was adherent to the bowel at one point. There was about a gallon of clear fluid in the abdominal cavity. In order to include with the growth the infiltrated broad ligament, the pedicle was ligated as near the uterus as possible. Patient rallied well and her convalescence was uneventful.

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There seemed little doubt on examination of the growth that hemorrhage took place in the broad ligament. The location of the cyst being high up might have produced traction sufficient to have ruptured a vessel or rupture of the vessel might have been caused by torsion of the long pedicle. If this patient had rallied from the shock of the hemorrhage, with the blood supply cut off by the infiltrated mass forming the pedicle, and the tense condition of the wall, no doubt the entire growth would have sloughed. At the time of the operation there had already been sufficient peritoneal irritation to produce rapid abdominal effusion.

According to Howell, American System of Gynecology, "The effusion of blood into the walls or cavities of ovarian cysts is by no means an uncommon accident, and may occur from any one of a number of causes, and at rare intervals a profuse intra-cystic hemorrhage may ensue without any assignable reason." Among other causes, he mentions the stretching which the cyst undergoes in growth as sufficient to rupture a vein but states that of all the causes of spontaneous hemorrhage the most frequent is torsion of the pedicle, that though the hemorrhage is generally slow and slight in amount, in some instances it is so profuse as to endanger the life of the patient. Thomas, in his text book, records two cases and Parry, American Journal of Obstetrics, records a case of dangerous collapse occasioned by sudden intra-cystic bleeding.

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MEDICAL FADS.

Medical men are only human beings and perhaps fools, or as big fools as the rest of mankind. The sheep herder on the mountain side knows only too well that one sheep can lead all others to destruction, for sheep blindly, senselessly, persistently follow a leader. Let mankind see a leader and away it goes, regardless of the rights and wrongs of life. Essentially we are imitators, and from the time that as babes we cease to nurse till death, ninety-nine out of every hundred follow the path indicated by some one else, the character and attainments of the some one else being of no consequence. Witness the great mass of people considered by their fellows to be sensible, well balanced people, who take up with this, that and the other fad, for such we, as medical men, can only consider the various heresies that faith leads the laity to consider proper means of curing their physical, and possibly mental ills.

Medical men are only made up of the same class of material as the rest of the world and differ by education only in their special calling. We have the same eyes, the same ears, the same qualities of speech, the same class of material in the cranium, and the same general characteristics, only we attempt to turn these qualities to a different purpose than the lawyer, the minister, the merchant, etc., and on account of that difference in education we see and condemn the follies and fallacies of the medical vagaries of our fellow men in other walks of life.

Should what we now have to say appeal to readers of this magazine we hope they will have a more charitable feeling towards those of our kind who take up with Christian science, osteopathy, and all ideas of homeopathy, eclecticism, etc. It is a case of using only that degree of brain power which nature endowed them with, and following the bent of that faith, which the things they believe they have seen and heard and correctly interpreted, lead them up to . In our profession there is one other thing that prompts us to follow fads, the desire to appear to be up to date, and to do the things for our profession that men, who at least are said to be leaders in the profession, do or have done, though they have discarded them long before they have come to the eyes and ears of ourselves.

Let us look at consumption and its treatment and see what doctors have taken up with. A few years ago Bourgeon launched a method of injecting sulphuretted gas into the rectum and colon, which gained credence in the minds of the profession and the laity to such an extent that it was only a short time until every hamlet in the land had one or more physicians who had conscientiously adopted the method and were treating some poor victim, who was only being kept from death by the mental stimulus that something new was producing upon his mind. Bourgeon's method was followed blindly and enthusiastically and harm was done many a poor sufferer because he was kept from going to the only hope that was left to him.

Again, Koch's lymph followed the same course, built up in the minds of mankind and the medical profession unbounded hope and enthusiasm, and probably did more harm than Bourgeon's method, especially in view of the reluctance that many of our profession have toward the use of tuberculin for diagnostic purpose.

Herschfelder, on this coast, in a laudable endeavor and a conscientious belief of doing good for mankind, had some followers, though fewer than he would have had, had not many before touched the fire and been badly burnt. But chief of all heresies in treating consumption and one that is clung to by many physicians of today, is cod liver oil, and the one that probably in itself does less good than any other nauseating substance with which we insult our patients by using.

Operative surgery, a great boon to the world, still is productive of many harms and exhibits many of the weaknesses of our race as exemplified in the medical profession. Many new men come to our state and, with few exceptions, they all would be surgeons. Operations done after the manner of some man of importance, of course, are the only ones and in unskillful hands would only do harm, and it is in this way that the general fad for operative surgery is harmful, though we do not wish to decry the fact that the progress operative surgery has made, is one of the greatest boons to humanity.

Of special note in operative surgery is the appendicitis, or more properly speaking, the appendectomy fad. Not long ago we saw a patient who had previously been operated upon and the appendix removed, who said, "This is what I got for being a friend of Dr.—." All over our country many appendices are removed whose only offense is that their proprietor has consulted a man with the appendectomy fad. This poor organ has become so obnoxious to the refined taste of the modern surgeon with the operative surgery fad, lending himself especially to abdominal work, that should it, in its pure and virgin state, be found fastened to a missionary cecum, it has to be sacrificed to the appendectomy fad.

Statistics and their upbuilding are dangerous fads, and when we read an article reporting so many cases of such and such an operation we feel that the writer has for a time at least, lost his balance and gone to the extreme to which the statistics fad leads one to. Not long ago a description of a new operation appeared and with it a report of twelve cases upon which it had been performed, and this in an extremely short time after the devising of the procedure. It is to be feared that nearly every case going to that surgeon had to pay the penalty by subjecting himself to a trial of the method. Surely, the learned gentleman should feel ashamed of himself that he did not sooner devise this method.

Only one more. For years anesthetics have been given and people have or have not vomited, depending upon many circumstances, and we know that many people have had anesthetics immediately after eating and nausea has not followed. But the present fad, in this part of the world, is to wash the stomach out before the case recovers from the anesthetic. But, strange to say, some of the patients vomit even after so scientific a procedure, and when we consider how an anesthetic produces nausea and vomiting, we can realize how senseless and unreasonable such a course is. We are told that in the one hospital in this country, where, we believe, the most careful, conservative and learned surgeons work, it was tried upon a series of cases and that just as many of them vomited as in other cases.

We hope that these few facts and instances may cause some to pause before blindly following the lead of others, just because it is the latest and most proper thing, and also reflect on the fact that we medical men are only human beings, subject to the same impressions of life as the rest of mankind. We should weigh better and longer than any other class of people what we do to our followers, for our fads may prove far more serious to our subjects than fads in any other calling.

DR. WILLIAM OSLER.

The expressions of regret on the part of the leading physicians from the Atlantic to the Pacific, on the departure of Dr. Osler from this country to England, testify to the respect and affection entertained for him by the profession of this country. He has many former students in the Northwest who will at this time join these in their expressions of admiration. As little is generally known of the chair to which he has been called at Oxford, the following quotations from the *Dominion Medical Monthly* will be of interest:

"This chair was one of five founded by King Henry VIII, in 1546, to each of which a yearly stipend of £40 was assigned. King James I. augmented the Professorship of the Hospital at Gwelme, in Oxfordshire. Later the Aldrichian Professorship of the Practice of Medicine, with an emolument of about £130 a year, was annexed to the chair. Dr. Osler, in addition to his duties as lecturer, will act as an examiner in all examinations for degrees in medicine granted by the University. Previous holders of the chair were: 1546, John Warner, D. M., Warden of All Souls; 1554, Thomas Francis, D. M., Ch.Ch.; 1561, Walter Bailey, B. M., Fellow of New College; 1597, Bartholomew Warner, D. M., St. John's; 1612, Thomas Clayton, D. M., Baliol, Principal of Broadgates Hall, Master of Pembroke; 1647, Thomas Clayton, sometime Fellow of Pembroke; 1665, James Hyde, D. M., Principal of Magdalen Hall; 1681, John Luffe, D. M., St. Mary Hall; 1698, Thomas Hoy, D. M., Fellow of St. John's; 1718, Joshua Lasher, D. M., Fellow of St. John's; 1729, William Beauvoix, D. M., sometime Fellow of Pembroke; 1730, William Woodford, D. M., Fellow of New College; 1759, John Kelly, D. M., Student of Ch.Ch.; 1772, William Vivian, D. M., Fellow of Corpus; Sir Christopher Pegge, D. M., Ch.Ch., sometime Fellow of Oriel; 1822, John Kidd, D. M., sometime Student of Ch.Ch.; 1851, James Adey Ogle, D. M., Trinity; 1857, Henry Wentworth Arland, D. M., Ch.Ch., sometime Fellow of All Souls; Dr. John Scott Burdon-Sanderson."

APPLICANTS BEFORE THE WASHINGTON EXAMINING BOARD DURING 1904.

The appended table presents the number of the candidates who appeared before the Examining Board at the two examinations of this year. The number, 182, is the largest on record for any one year and is an indication of the growth of the population in the state. The evidence of the cosmopolitan character of our profession is shown by the fact that the new supply came from twenty-five different states and countries, representing America, Europe and Asia. Although this is commonly known as a young man's country attention is directed to the number of old graduates, as indicated by the recorded years of graduation. That the Board evinced a commendable scrutiny of the qualifications of the applicants is demonstrated by the fact that 25.3 per cent. failed to pass. We believe the work of the Examining Board should meet the approval of the profession and their efforts sustained in the attempt to maintain a high standard of efficiency.

MEDICAL COLLEGE.	PASSED.	FAILED.
California—		
California Medical College		(1902) 62, 67; (1904) 73
College of Physicians and Surgeons of San Francisco	(1891) 81	
Cooper Medical College	(1890) 77	
Canada—		
McGill University	(1903) 86	
Toronto University Medical Faculty	(1892) 71; (1899) 84;(1903) 91	
Trinity Medical College	(1897) 80: (1901) 83; (1902) 81; (1903) 75, 82; (1904) 81	(1902) 72; (1903) 73
Colorado—		
Colorado School of Medicine (State University)	(1903) 74	
Gross Medical College	(1896) 79	(1900) 63

District of Columbia—		
University of Georgetown	(1891) 81; (1897) 77; (1903) 78, 80	
France—		
University of Paris		(1897) 61; (1900) 70
Georgia—		
Atlanta College of Physicians and Surgeons	(1889) 72*; (1894) —†	
Georgia College of Eclectic Medicine and Surgery		(1882) 59
Germany—		
University of Heidelberg	(1903) 82	
Holland—		
University of Amsterdam	(1887) 83	
Illinois—		
American Medical Missionary College	(1900) —†	
Bennett College of Eclectic Medicine and Surgery	(1898) 78	
College of Physicians and Surgeons of Chicago	(1878) 89; (1892) 82: (1902) 81: (1903) 76, 81; (1901) 88	(1902) 58
Harvey Medical College		(1904) 70
Northwestern University Medical School	(1887) 92; (1896) 83; (1902) —† (1903) 92; (1904) 78, 81, 85, 87, 87	
Rush Medical College	(1890) 70*; (1896) 75; (1894) 78; (1899) 89, —†; (1901) 80; (1902) 83, 84; (1903) 78, 86	(1897) 72
The Chicago Homeopathic Medical College	(1894) 82; (1902) 85; (1904) 82, 83	
Indiana—		
Indiana Medical College	(1902) 83	(1901) 70
Iowa—		
State University of Iowa College of Medicine	(1875) 75; (1904) 83	(1901) 72; (1893) —†
Japan—		
Kioto Medical College	(1893) 75	(1893) 45
Kansas—		
The Kansas Medical College	(1886) 82	(1899) 63
Kentucky—		
Kentucky School of Medicine	(1896) 88; (1897) —†; (1899) 74; (1903) 75	
Louisville Medical College	(1898) 75, 82	(1898) —†
University of Louisville		(1900) 74, —†

Maryland—		
Baltimore Medical College	(1903) —†	
Medical Department of the Johns Hopkins University	(1904) 87	
University of Maryland School of Medicine	(1900) 79; (1901) 91	(1904) 68
Massachusetts—		
Harvard University Medical School	(1901) 81; (1903) 82	
Michigan—		
Detroit College of Medicine	1888) 70,—*; (1892) 87; (1897) 76; (1902) 85; (1903) 83	
Sagniaw Valley Medical College	(1899) 76, —†; (1903) 85	(1903) 70
University of Michigan	(1877) 71*; (1893) 78; (1897) 86; (1899) 86; (1902) 82, 87; (1904) 83	(1901) 61
Minnesota—		
Medical Department of Hamline University	(1897) 80; (1900) 78; (1903) 88	
The college of Homeopathic Medicine and Surgery of the University of Minnesota	(1903) 85	
The College of Medicine and Surgery of the Univ. of Minn.	(1882) 81; (1893) 76; (1897) 76; (1903) 82, 84, 86; (1904) 78	
Missouri—		
Barnes Medical College	(1882) 73*; (1898) 79; (1904) 83	(1903) 67; (1901) 67
Ensworth Medical College (St. Joseph Med. Col.)		(1903) 64
Hahneman Medical College of the Kansas City University		(1902) 67
Kansas City Medical College	(1879) 75, 70*	(1896) 62; (1898) 61, —† (1900) —†
Missouri Medical College	(1873) 70*; (1896) 81; (1901) 85	(1893) 63; (1896) 59
St. Louis College of Physicians and Surgeons	(1904 89	
The Central Medical College		(1898) 70
The Marion-Sims College of Medicine	(1897) —†	
University Medical College of Kansas City	(1886) 78	(1898) 42
Nebraska—		
Lincoln Medical College	(1897) 71	(1902) 58
Omaha Medical College		(1880) 59, 64
The John A. Creighton Medical College	(1902) 91; (1904) 79	
New York—		
Albany Medical College	(1901) 85	
Bellevue Hospital Medical College	(1876) 82; (1890) —†; (1896) 83; (1899) 84	
College of Physicians and Surgeons in the City of New York	(1903) 82	
Long Island College Hospital	(1894) —†	
Syracuse University, College of Medicine	(1896) 87	

Ohio—		
Eclectic Medical Institute		(1900) 72
Medical Department of Western Reserve University	(1903) 86	
Miami Medical College	(1904) 82	
Ohio Medical University	(1891) 80	
Pulte Medical College		(1904) 60
Starling Medical College	(1895) 82	(1895) 66; (1901) 70
Oregon—		
University of the State of Oregon, Medical Department	(1903) 81; (1904) 80; (1904) 83	
Willamette University, Medical Department	(1904) 77	(1904) 70
Pennsylvania—		
Department of Medicine of the University of Pennsylvania	(1882) 87; (1902) 91	(1897) —†
Hahnemann Medical College	(1902) 78; (1903) 86	
Jefferson Medical College	(1896) —†; (1891) 83; (1897) 82; (1903) 81	
Tennessee—		
Chattanooga Medical College (Med. Dept. of Grant University)		(1904) 69
Medical Department of the University of Tennessee		(1889) 66
Vanderbilt University, Medical Department	(1884) —†	
Name of College illegible		(1875) 24
Total	135	47

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*Old graduates, of 10 or more years standing. An average of 70 is required for passing. Others must attain an average of 75%.

†Averages not recorded.

MEDICAL NOTES.

The Portland Preparations for the A. M. A.—The profession of Portland has started the ball rolling for the great event of their history. There is no doubt of their ability to suitably entertain the American Medical Association. Five of the leading physicians have individually subscribed $500 each, and a long list of large subscriptions will follow. Splendid facilities will be provided for the section sessions, and any congestion on account of threatened lack of hotels has been relieved by the action of the Lewis and Clark Fair directors in making arrangements to build a good hotel near the fair grounds, not more than ten minutes from the center of the city, with accommodations for 1,500 to 2,000 guests. Our Eastern friends may rest assured that they will be received and entertained in a manner to raise the wish soon again to visit the Pacific Coast.

The Blue Mountain Sanatorium.—It is of value to know that a fully equipped institution for the modern treatment of tuberculosis is conveniently located in the Northwest. Dr. Bingham's Sanatorium, of which a description is to be found in our advertiser, will appeal to the profession. Being familiar with its location and surroundings, we feel assured it is not necessary to send tubercular patients a long distance from home when they can receive modern treatment at a properly conducted institution at such an available situation. There is no reason why we should not as well treat the disease to a successful termination in this as other sections of our land.

Lewis County Medical Society.—The physicians of Lewis County have fallen into line and organized a county society. The meetings are to be held the first Monday of each month, at such places as will be most convenient for the members. The officers are: President, J. T. Coleman, Chehalis; Secretary, Chas. Harden, Pe Ell; Treasurer, Thos. Primmer, Centralia. We wish success and prosperity to the youngest member of our component societies.

The Wayside Emergency Hospital.—This is the name under which the old Wayside Mission Hospital, of Seattle, has recently been incorporated, with Mrs. F. W. Cannon as manager. Important improvements have been made, greatly to its advantage as an efficient institution. The following visiting staff has been appointed: Surgical U. C. Bates and J. E. Harris; medical, J. W. Bailey; opthalmologists, C. T. Cook and A. W. Hawley. W. S. Griswold is the resident physician. Consulting Staff, J. B. Eagleson, C. W. Sharples, C. A. Smith, J. P. Sweeney and J. A. Mackinnon.

The Death of Mrs. Margaret Duxfield Livingstone Cane.—Mrs. Cane died of nephritis at White Horse, Y. T., Sept. 4. She was born in England where she lived till 1888, when she arrived in New York to enter the Bellevue Training School for Nurses. After her graduation, in 1890, she devoted most of her time for eight years to the work of superintendent of hospitals and training schools in several Eastern cities. She came to Seattle, as Mrs. Livingstone, in 1898, to assume the superintendency of the Seattle General Hospital and Training School for Nurses. During her two years of service in this capacity she exhibited an unusual efficiency in this line of work. Her familiarity with all the details of hospital affairs and a commanding executive ability made her an ideal head for such an institution. Through her relations with the medical profession she secured firm friends among the physicians of Seattle, while her cheery disposition won a circle of admirers among all who knew her. In 1901 she made her residence in Alaska, marrying Dr. F. W. Cane, of White Horse, about two years ago.

Examination for Embalmer's License.—The Washington State Board of Health held this examination at North Yakima, Sept. 30. The questions asked the applicants covered the subjects of disinfectants and their uses; contagious diseases and the methods of guarding against them by the embalmers; some general questions on anatomy, especially the location of arteries; knowledge of the rules and regulations of the State Board of Health. Twenty-nine applicants were examined, of whom twenty-seven were successful.

Corrections in the list of members of the State Association.—Through an error the list of members from the Snohomish County Society, as published last month was inaccurate. That from Thurston County did not appear. The corrected list is as follows:

SNOHOMISH COUNTY.

E. M. Adams, Arlington.
B. L. Baker, Everett.
C. A. Betts, Everett.
J. G. Byrne, Everett.
Jas. Chisholm, Everett.
W. C. Cox, Everett.
W. S. Durand, Everett.
J. R. Hathaway, Everett.
F. R. Hedges, Everett.
H. P. Howard, Everett.
Wm. Jenner, Everett.
J. L. Manning, Everett.
Daniel McEchran, Everett.
C. A. Mead, Everett.
J. S. Newcomb, Everett.
P. L. Opsvig, Everett.
Cora-Turner Saxe, Everett.
J. E. Stauffer, Everett.
W. F. West, Everett.
C. L. Munn, Marysville.
L. L. Stephens, Monroe.
J. A. Durrent, Snohomish.
Thos. Keefe, Snohomish.
N. S. McCready, Snohomish.
H. K. Lum, Stanwood.
O. S. Allen, Stanwood.
F. S. Sanborg, Sultan.

THURSTON COUNTY.

G. W. Ingham, Olympia.
R. Kincaid, Olympia.
J. W.Mowell, Olympia.
N. J. Redpath, Olympia.
H. S. Strickland, Olympia.
H. S. Wyman, Olympia.

TO OUR READERS AND CONTRIBUTORS.

All material for publication must be received by the first day of the month. Articles will be illustrated by half-tones or etchings when accompanied by photographs or drawings for the same. Reprints of contributed articles can be obtained at the cost of publication, from the Metropolitan Press, publishers of the journal. A limited number of additional copies of the journal will be supplied to contributors, if a request is made for them.

TO ADVERTISERS.

We wish to call attention to the fact that Northwest Medicine has no department for reading notices, publishers' notes, etc., and that reading matter and advertising pages are entirely distinct.

REPORTS OF SOCIETY MEETINGS.

TWELFTH ANNUAL MEETING OF THE IDAHO STATE MEDICAL SOCIETY.

Held at Lewiston, October 6th and 7th, 1904.

The Society convened in general session, in the Masonic Hall, at 11:20 a. m., October 6, with Vice-President, Dr. R. L. Nourse, of Hailey, in the chair, the President, Dr. J. L. Conant, Jr. of Genessee being absent. In the absence of the Secretary, Dr. Ed. E. Maxey, Dr. C. C. Phillips, of Lewiston, was appointed temporary Secretary.

Owing to the fact that the Secretary's records and reports were lost in transit from Boise to Lewiston, the reading of the minutes of the last meeting, and the reports from the Council, Secretary-Treasurer, and the Standing Committees, were omitted. The Committee on Arrangements reported that they had secured the Temple Theatre for th general meetings of the Society, and that the banquet would be held at the Raymond House, on Friday evening. On motion the committee's report was accepted, with the amendment that the banquet be held Thursday evening instead of Friday, and the committee was instructed to order banquet for twenty-five.

A communication from Secretary, Ed. E. Maxey, was then read, in which he stated his inability to attend this meeting.

At this point, Dr. Phillips was called away, and Dr. F. L. Hinkly was appointed Secretary pro tem for the remainder of the meeting.

The matter of forming a North Idaho District Medical Society was then taken up, informally, and freely discussed by Drs. Nourse, Morris, McCalla, Lyle, and Hinkly but no definite action taken at this time.

The application of J. G. Lentz of Ilo, and M. E. Alexander of Mullan, were read and, upon being reported favorably by board of examiners, they were elected to membership in the State Society, the last name subject to the payment of his fee.

The Society reconvened at 1:55 P. M., with Dr. Nourse in the chair. On motion, the application of O. S. Page, of Sand Point, received by telegraph, was received and, subject to the payment of the fee, Dr. Page was duly elected to membership. On motion the applications of Drs. T. O. Boyd, of Post Falls; A. J. Douglas, of Melrose, and Joseph Asprey, of Moscow, were received and they were elected to membership, subject to the condition that they pass the State Board of Medical Examiners now in session and the payment of the membership fee. The applications of Drs. J. B. Coburn and Eli Taylor, of Nez Perce, were read and on motion both were elected to membership.

A recess was then ordered for the purpose of allowing the North Idaho members an opportunity to organize a district society.

On reconvening at 2:30, it was reported that a temporary organization of the North Idaho District Medical Society had been made by electing Dr. J. N. Alley, of Lapwai, President; Dr. J. B. Morris, of

Lewiston, Vice-President; Dr. J. M. Lyle, of Peck, Secretary; that a committee consisting of Drs. F. L. Hinkly and J. F. Hurlburt, of Lewiston, and John Coburn, of Nez Perce, was appointed to draft a constitution and by-laws, and that a meeting had been ordered for October 20th, 1904, to meet at Dr. Hinkly's office in Lewiston, for the purpose of perfecting a permanent organization.

Burns, the Most Frequent Complications and Treatment.—This paper was read by Dr. J. N. Alley, of Lapwai.

Electric Burns—Was read by Dr. J. B. Morris, of Lewiston, Discussion was opened by Dr. McCalla, of Boise, followed by Drs. Nourse and Hinkly, and closed by Drs. Alley and Morris.

Diseases of the Prostrate and Their Treatment.—This paper was read by Dr. L. P. McCalla, of Boise. It was discussed by Dr. Thomas, of Spokane, and others, and closed by Dr. McCalla.

A motion to proceed with the nomination and election of officers in open meeting was carried. After a recess of fifteen minutes, the application of Dr. S. A. Roe, of Lewiston, was read and he was elected to membership in the usual manner.

Under the order of business, election of officers, Dr. J. B. Morris, of Lewiston, was nominated for President. Dr. Morris withdrew his name and placed that of Dr. R. L. Nourse, of Hailey, nomination. On motion, the nominations for President were declared closed and Dr. Nourse was elected by acclamation.

Dr. J. B. Morris, of Lewiston, was then nominated for Vice-President and elected by acclamation.

The following chairmen of Standing Committees were then elected by acclamation: Committee on Legislation, Dr. L. P. McCalla, of Boise; Committee on Nominations, Dr. J. N. Alley, of Lapwai; and Committee on Publication, Dr. Ed. E. Maxey, of Boise. On motion the President was instructed to appoint a chairman for the Committee on Public Health and Medical Charities.

On motion, Boise was selected as the place for the next annual meeting, and Dr. C. L. Sweet, of Boise, was elected chairman of the Committee on Arrangements.

The application of Dr. R. S. Gregory, of Boise, was read and the doctor was elected to membership in due form.

On motion the committee on legislation was instructed to use its influence to have an amendment to our medical law passed that would permit of reciprocity with states having an equally high standard as Idaho, licenses to be given only to those licentiates of other states who have passed the written examinations. The subject was freely discussed by Mrs. McCalla, Nourse, Hinkly, Thomas, Gregory, Lentz, Roe, and others. A motion to amend the above motion by restricting the reciprocity to the states of Washington, Oregon, Utah and Montana was carried, and the entire motion as amended was then adopted by the Society. Adjourned to 8 P. M.

The Society was again convened at 8:35 P. M. by Vice-President Dr. Nourse.

Pleuro-Pneumonia.—Written by Dr. M. E. Alexander, was read by Dr. McGhan, of Lewiston. It was discussed by Drs. Alley, Thomas and Lyle.

Surgical Complications.—Was the subject of a paper read by Dr. C. P. Thomas, of Spokane, which was discussed by Drs. McCalla and Alley, and closed by Dr. Thomas.

Treatment of Displacements of the Uterus and Concomitant Pathologic Conditions.—This paper was presented by Dr. R. C. Coffey, of Portland. It was illustrated with numerous drawings. It was discussed by Drs. McCalla and Thomas, closed by Dr. Coffey.

On motion the Society adjourned.

KING COUNTY MEDICAL SOCIETY.

President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

The first regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce on the evening of October 3, President Heg being in the chair. Thirty-five members and visitors were present.

Dr. R. L. Keith was elected to membership.

PATHOLOGIC CASES.

An Open Safety Pin in the Esophagus of a Child of Four and a Half Years.—Dr. Eagleson described the case of this child, whose father presented him, stating that a safety pin had been swallowed and was thought to have lodged in the throat. The doctor made a radiograph, which displayed the open pin in the upper part of the esophagus with the open end pointing upward. He proposed an operation for its removal, which the parents would not accept. He used a probang, which was passed into the esophagus and the pin pushed into the stomach. Four days later it appeared in the stool, no harm having come to the child. The radiograph was exhibited.

Accidental Resection of the Ureter, Followed by Nephrectomy.—Dr. Eagleson presented a globular tumor about six inches in diameter, which he removed from the left upper angle of the uterus. Its origin and character were obscure. It resembled a fibroid, but the pathologic report had not yet been made. A portion of the uterus was removed with it. Also it was attached to the tissues in the left illiac region in such a manner that on examination after removal it was found to involve about three inches of the left ureter, which had been unwittingly excised with it. The separation was so great between the exposed ends of the ureter that an anastomosis was considered impossible. The location of the excision was such that an anastomosis with the bladder was impracticable. Accordingly the left kidney was removed. The patient made an uneventful recovery.

Nephrectomy for Tubercular Pyonephrosis.—Dr. Eagleson presented a kidney removed a week ago from a woman, with the following history: Two years ago she was treated for a floating kidney in an Eastern city. Last winter she came to Seattle and the doctor saw her in February. At that time she exhibited symptoms of pyonephrosis and he advised an operation, which was refused. In April he did a nephrotomy and evacuated considerable pus. She left him and returned two weeks ago. No examination was made for tubercle bacilli at the first operation, but they were found in abundance in the urine at this time. The nephrectomy followed.

Stone in the Urethra.—Dr. Carroll presented a stone about the shape and size of a cartridge, weighing gr. 94, obtained by operation from a man of 71 years, with the following history: Fifteen years ago he had a sudden difficulty with urination. He found the flow obstructed by something in the urethra. By manipulation he could press it to one side and thus urinate. This maneuver has been necessary for the subsequent years. When he came to the doctor he had a tumor the size of an orange in front of the testicles, beneath the urethra. A physician had attempted to pass a catheter the day before, but failed. No urine had been voided for thirty-six hours and the man was uremic. The tumor was incised, pus evacuated and this stone found, imbedded in the urethra. The bladder was full of pus. It was drained by catheter. For four days he was comatose. Then he improved and sat up on the fifth day. He became delirious on the ninth and died on the twelfth day.

Dr. Schoenle said it was remarkable that the stone should have remained so long in the urethra. They often pass unnoticed. He thinks the best treatment is a perineal section. The patient probably died of uremia.

Dr. Peterkin thought that, in a man of that age, the best treatment is to open the bladder and evacuate the urine.

Dr. Hawley related an acute case where, in twenty-four hours, the stone perforated the urethra and the urine extravasated extensively. He performed a perineal section and had no difficulty in removing the stone from the anterior urethra. He thought the case described probably died from urinal infection.

PAPERS.

Traumatic Aneurism of the Femoral Artery.—Dr. F. M. Carroll read this paper. The patient was mending a belt when the knife fell, striking the thigh and injured the femoral artery so as to produce a large aneurism. After using different local applications he cut down on it and tied the injured vessels.

Dr. Allen described a case where the man's arm was injured by the tooth of a saw, producing an aneurism of the radial artery. It was cured by operation.

Aortic Regurgitation.—Dr. Ostrom read a paper on this subject. He gave a resume of the pathology, symptoms and treatment of this condition. He described a case treated some months ago, in a man of 40 years. He suffered an apopleptic stroke, after which the previous symptom disappeared.

The paper was discussed by Drs. Carroll, Winslow, Harris, Sweeney and Davis.

The second regular semi-monthly meeting of the King County Medical Society was held at the Seattle Chamber of Commerce on the evening of October 17. In the absence of the president, Dr. Miles occupied the chair. Thirty members were present.

Wm. McDowell was elected to membership. The applications of L. H. Redon and F. L. Horsfall were received and referred to the committee on admission.

PATHOLOGIC SPECIMENS.

Enchondroma of the Ribs.—Dr. Sharples presented the specimen, stating it was removed from the region over the heart. The man received a blow here a few years ago. About a year ago this growth began, giving no pain, but annoying from its presence. It was globular, lobulated, about two inches in diameter, of rubbery consistence on section. In the center was a small cavity filled with blood. Microscopic section presented a characteristic picture of cartilage structure.

Nephrectomy for Tubercular Pyonephrosis.—Dr. Sharples presented a kidney, obtained from operation, which was performed in consequence of its containing an abscess. Tubercle bacilli were not found in the urine. Previous to the operation the patient voided eighteen ounces of cloudy urine. After operation it rose to twenty-four ounces of clear urine daily.

PAPERS.

Early Diagnosis of Tuberculosis.—Dr. H. Stillson read this interesting paper, reciting the various signs and means of diagnosis available previous to the discovery of bacilli in the sputum. He dwelt especially on early diagnosis in children and young adults, mentioning inherited tendency, contour of chest, abnormal features of respiration, indications in the larynx, blood examinations and early evidences obtained by radiography. He dwelt on the tuberculin test, thinking this should not be used in persons of weak constitution nor till other means of diagnosis had been exhausted.

Hemoptysis as the Earliest Manifestation of Tuberculosis.—Dr. W. N. McLaughlin read the history of a sailor whom he treated on board ship. He had been in good health and complained of nothing till an hempotysis appeared, of moderate degree. No physical signs were discovered to explain it, and at first the blood was supposed to have come from the mouth or nose. It reappeared, accompanied by fever, cough and emaciation. It was more than a month before he could be sent to the Marine Hospital, where the disease advanced rapidly and the patient died, eighty days after the first hemorrhage.

Dr. Thomson presented a radiograph of a chest, showing consolidations at the apices and borders of the lungs, in whom no physical signs were discovered.

Dr. Read commented on our responsibility in making an early diagnosis. So much may depend on it that a decision should not be made till all clinical and chemical aids available have been employed. He mentioned the Diazo reaction, which is positive in most tubercular patients. He controverted the popular opinion that the tuberculin test is dangerous. It gives early information and is in daily use in some parts of the world.

Drs. Smith and Sharples related cases illustrative of the papers read.

RECENT PROGRESS IN MEDICINE AND SURGERY.

SURGERY.

Edited by

J. B. Eagleson, M. D.; E. E. Heg, M. D.

Antiseptic Surgical Technique.—By A. J. Ochsner, M. D., Annals of Surg., Oct. 1904.

The writer outlines the methods followed in the work at the Augustana Hospital, Chicago. In order to secure the best possible results a system must be (1) simple and yet comprehensive; (2) it must be uniform, and (3), above all things, it must be reasonable

This system must be carefully learned by all assistants and nurses. The field of operation is prepared the night before by thorough scrubbing with soap, shaving and strong alcohol; then covered by a moist dressing of gauze saturated with three per cent. carbolic solution. Just before operation it is again scrubbed with strong alcohol. In the preparation of hands of operator and assistants he insists that the skin shall be kept in a soft and pliable condition and free from contamination with pus. Assistants and surgical nurses wear rubber gloves during all operations, while the operator wears them only in operation in the presence of pus. Great care is taken not to breathe or speak into the wound.

All instruments, except knives, are boiled for half an hour in a solution of soda. Knives are washed carefully with water and then rubbed with pads of cotton soaked in alcohol. Silk, silkworm gut, horsehair, drainage tubes, and brushes are boiled for an hour in water and preserved in a five per cent. solution of carbolic acid. All dressings are disinfected in a steam sterilizer; all basins, instruments pans, jars for dressing, etc., are boiled for an hour in soda solution and kept wrapped in sterilized sheets until used. Tables are scrubbed with soap and water, and then with 1-1000 corosive sublimate solution.

Drainage is always used in very large wounds, and whenever there is any doubt concerning the aseptic condition of the wound. Irrigation is practically never used during operations, either in the abdominal cavity or elsewhere.

Ochsner believes that the only form of infection which must be considered in surgery is contact infection, which is due to the introduction into the wound of septic material from unclean hands, instruments, sponges, or dressings, or from speaking or breathing into the wound. Eagleson.

Antiseptic Surgical Technique.—By Geo. N. Monks, M. D., Annals of Surg., Oct. 1904.

The writer gives the following summary of the minimum requirements for aseptic surgical work in a large general hospital:

1. Materials to be sterilized in saturated steam, in the autoclave, for one-half hour, under fifteen pound's pressure; rubber gloves and

salt solution under ten pounds' pressure. If there is not sufficient space in the autoclave for the gauze dressings they may be baked.

2. In hospitals without proper facilities for the sterilization of absorbable ligatures, these to be obtained from reliable dealers whose business reputation is at stake.

3. An operating room which can be easily cleaned, and which is cleaned, where the air is kept as free from dust as possible, where draughts are minimized, and where formalin fumigation is thorough and systematically practised.

4. A hot bath for the patient, and a cleansing and shaving of operating area the night before operation if possible (as an extra precaution). Just before operation a second cleansing, and sterilization with 70 per cent. alcohol or some equally efficient method.

5. Thorough mechanical cleansing of the hands, and sterilization by 70 per cent. alcohol or some equally efficient method.

6. Ten minutes' boiling for instruments, special attention being paid to taking apart clamps and hemostatic forceps, or at least unlocking them.

7. Caps, masks, and sterile gloves always to be worn, at least on major cases.

8. Warm sterile salt solution for irrigation and washing.

9. Belief in the aseptic idea, fixed aseptic habits, and aseptic co-operation on part of all engaged in an operation.

10. Instruction of assistants and nurses as above set forth.

Eagleson.

Some Studies in Asepsis.—By Charles Harrington, M. D., Annals of Surg., Oct., 1904.

He gives the results of a series of experimenttal studies of the various disinfectants and antiseptics in use and from these believes that he has found a new combination which is much more effective than any of them used independently. It is as follows:

Commercial Alcohol (94 per cent.)	640 cc
Hydrochloric Acid	60 cc
Water	300 cc
Corrosive Sublimate	0 8 gm

This mixture contains, then, 60 per cent. absolute alcohol, 6 per cent. commercial hydrochloric acid, and 1-1250 corrosive sublimate.

He claims that this mixture will kill pus germs in from 30 seconds to one minute, and has but little if any deterious effect on the skin

Eagleson.

DISEASES OF CHILDREN.

Edited by

G. B. McCulloch, M. D.; C. B. Ford, M. D.

An Analysis of 118 Cases of Lobar Pneumonia in Infancy.—By J. L. Morse, M. D., Archives of Pediatrics, Sept. 1904.

The important points of the article are well brought out in his summary which we quote in full.

"Lobar pneumonia is more common and occurs relatively more frequently in comparison with broncho pneumonia in infancy than is generally supposed. The analysis of these cases shows the following points: The onset was less stormy than was generally thought. It was often ushered in by vomiting, but rarely by a convulsion. It usually began with fever and cough, which were often accompanied by apathy or drowsiness. Movement of the alae nasi was not a constant symptom. A whole lobe was more often involved than a part. The left lower lobe was the one most commonly involved. The right upper lobe and right lower lobe came next in frequency. The portion of the lungs involved was relatively the same in the fatal cases as in those which recovered. As a rule, the area involved was larger in the fatal cases. The average duration of the fever in the cases that recovered was about eight days, being nearly the same in both years. The course was more often short in the first year, however, than in the second. The average duration of the fever in the uncomplicated fatal cases was 12.8 days; that is, the duration of the fever was longer in the fatal cases than in those that recovered. The highest temperature was usually between 103° F. and 106° F., the number of cases being nearly the same for each degree.

The temperature fell by crisis in 68.8 per cent. Crises were less common in the first than in the second year. Collapse during the crisis was very unusual. Pseudo-crises were not very common, but irregularities and remissions in the temperature were not at all unusual. The mortality was lowest when the temperature did not rise above 103° F., and highest in those cases in which it went over 106° F. The degree of fever between 103° F. and 106° F. had no apparent effect on the mortality. A high temperature was no more fatal in the second than in the first year. The usual pulse rate was between 150 and 170. No case died in which the pulse was not over 140. The rate of the pulse, when it was above 140, had little or no apparent influence on the mortality. The usualy respiratory rate was between 55 and 80. No case died in which the respiration was below 55. The rate of respiration, when above 55, had no apparent effect on the mortality. The mortality, excluding the cases in which death was due to empyema, was nearly 23 per cent. It was almost twice as great in the first as in the second year, being 32 per cent. and 18 per cent. respectively.

Otitis media was the most common complication, occuring in 18 per cent. Empyema was the next most frequent, occuring in about 8 per cent.

The prognosis varies decidedly with the age of the infant and, to a certain extent, with the amount of lung involved. The prognosis is good when the temperature is not over 103° F. It is serious when above 106° F. The prognosis is good when the pulse is not over 140 or the respiration over 55."

The following important points were brought out by the discussion.

The respiration and pulse were taken when the infants were quiet, and if possible asleep. It is the quality and not the frequency of the pulse which is the important factor. Most present thought that the mortality rate given was too high. It is important to leave the patients alone as much as possible. They should have the greatest possible amount of fresh air, be properly fed and have the bowels kept open.

FORD.

BOOK REVIEWS.

Edited by
Kenelm Winslow, M. D.

Progressive Medicine, Vol. III, September, 1904. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, 284 pages, 19 illustrations. Per annum, in four cloth-bound volumes, $9.00; in paper binding, $6.00, carriage paid to any address. Lea Brothers & Co., Publishers, Philadelphia and New York.

As our readers probably know, Progressive Medicine covers methodically the whole domain of medicine during the year, certain issues containing certain departments. In the present volume are contained the year's sections on Diseases of the Heart, Lungs and Bloodvessels, edited by Ewart, of London; Dermatology and Syphilis, by Gottheil, of New York; Diseases of the Nervous System, by Spiller, of Philadelphia, and Obstetrics, by Norris, of Philadelphia.

Among the events in progress we note of interest so many that enumeration becomes impossible. The replacement of air by allowing it to filter into the pleural cavity through the cannula, covered with several layers of aseptic gauze after fluid has been withdrawn from the pleural cavity, to obviate pain, edema and return of pleural effusion, is highly approved of by many authorities. The increasing importance of the sphygmomanometer is attested by several writers, and the absolute failure of alcohol to show any evidence of stimulating the circulation is one of the startling revelations of this exact method of determining blood pressure.

Cardioptosis is found associated with hepatoptosis and enteroptosis, and is the latest development in the discovery of the abnormal displacement of organs. The change in position of the heart results in a dropping down of the organ, which may be followed by symptoms such as palpitation, rapid or slow pulsation, vertigo, etc., and is remedied by measures calculated to improve splanchoptosis generally. Turning to dermatology, the view is expressed by recent medical opinion that eczema is not a distinct disease at all, but reflects the effects of varied reactions of the skin to varied internal and external stimuli, the result differing with the individual peculiarities. This greatly widens the field of our efforts, which should be directed to discovering any possible source of external and internal irritation and renders the value of strict local treatment less prominent. The injection of a few drops of a 2-3% solution of carbolic acid into budding boils appears to be the treatment of these lesions which is superior to all others, according to the results of accumulating experience.

The section on obstetrics is particularly interesting and also is the progress in neurology carefully compiled, but unfortunately space alone forbids us from writing a second volume on the one in hand. We reiterate what we have so often said before, that Progressive Medicine stands at the head of anything of its kind published in the English language which has come under our notice. WINSLOW.

Magee & Johnson's Epitome of Surgery.. A Manual for Students and Practitioners. By M. D'Arcy Magee, A. M. M. D., Demonstrator of Surgery and Lecturer on Minor Surgery; and Wallace Johnson, Ph. D., M. D., Demonstrator of Pathology and Bacteriology in Georgetown University Medical School, Washington, D. C. In a 12 mo. volume of 295 pages, with 129 engravings. Cloth, $1.00 net. Lea Brothers & Co., Publishers, Phila. and New York, 1904.

The latest volume in the MEDICAL EPITOME SERIES is before us. We fear that the attempt to crowd all the essentials of surgery into the compass of the little volume is to attempt the impossible. Only surgical maxims can be expected, and on this account perhaps it is supererogation to criticize. But in the following particulars it has seemed that the essentials are omitted. In the treatment of fractures no mention is made of anesthesia as a means of diagnosis; under "Symptoms of gallstones or infection of the gallbladder," we find only the following are given: "Frequently recurring attacks of "hepatic colic, jaundice, and ensuing cholemia resulting from obstruction in the hepatic or common bile-duct."

The omission of local tenderness and absence of further description of the location of pain seem important. On the other hand, under Appendicitis five types of the diseases are described, with recommendations for treatment, such as cases with severe pain and tenderness and swelling in the right inguinal region, with a temperature of 101° to 102° and pulse of 120 accompanied with vomiting "may be considered as a possibly severe form of catarrhal appendicitis and may receive conservative treatment."

The best conservative treatment at the present day is generally held to be operation in the early hours of the attack unless the object be to conserve the appendix rather than the patient.

An excellent epitome of X-ray surgery is appended to the little manual. Although there must be much difference of opinion as to what are the essentials of surgery, yet we believe that the present volume would be much improved were its scope considerably increased.

WINSLOW.

The Doctor's Red Lamp.—343 pages, illustrated, Cloth, $2.50. The Saalfield Publishing Co., New York, Chicago, and Akron, Ohio.

This is the second volume of The Doctor's Recreation Series, the first of which we reviewed not long since. It consists of a collection of twenty-two short stories concerning the Physician in his daily life. As the stories are selected with this end in view it can be readily conceived that their literary excellence can not be ideal. Still if we are not so egotistic as to like best matter which is written about ourselves, yet we all possess a certain amount of curiosity to learn what others think about us and especially the degree of ignorance which the lay writer is capable of committing in the portrayal of medical personalities. There are, however, many well written tales and also some true to life as the names of Conan Doyle, Henry Seton Merriman and Ian Maclaren, among the writers, will testify. Perhaps the most strenuous and interesting of any is the story of Dr. Barrere, by Margaret Oliphant, which is the longest and strongest and rivets attention from start to finish. The book is well gotten up, is worth reading and will serve to while away the leisure hour.

WINSLOW.

REPORT OF CONTAGIOUS DISEASES.

To the Washington Board of Health for September, 1904.

Counties.	Smallpox		Scarlet Fever		Diphtheria		Typhoid Fever	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Adams	0	0	1	0	0	0	4	0
Adams	0	0	1	0	1	0	6	0
Asotin	0	0	0	0	0	0	1	0
Chehalis	0	0	0	0	2	0	10	0
Chelan	0	0	0	0	0	0	4	0
Clallam	0	0	0	0	0	0	1	0
Columbus	0	0	1	0	0	0	4	1
Douglas	0	0	0	0	1	0	7	1
Jefferson	0	0	0	0	4	2	0	0
King	0	0	10	0	14	2	3	0
Kitsap	0	0	0	0	2	0	0	0
Kittitas	0	0	0	0	1	0	0	0
Lewis	0	0	0	0	0	0	12	0
Lincoln	0	0	0	0	0	0	28	0
Pacific	0	0	5	0	0	0	0	0
Skagit	0	0	0	0	0	0	2	0
Spokane	0	1	0	0	1	1	0	0
Thurston	0	0	0	0	0	0	4	0
Walla Walla	0	0	1	0	11	0	18	1
Whatcom	3	0	0	0	0	0	0	0
Whitman	0	0	0	0	1	0	9	1
Yakima	7	0	0	0	5	1	63	5
Bellingham (city)	0	0	0	0	1	0	4	0
Seattle (city)	0	0	4	0	18	3	38	5
Spokane (city)	1	1	9	0	26	2	20	7
Tacoma (city)	0	0	4	0	4	0	11	0
Total	11	2	35	0	92	11	245	21
September, 1903	44	4	50	1	26	4	101	20
Total, 1904	281	9	851	36	860	115	670	96
Same period 1903	789		748		193		147	

While the reports show an increased number of diptheria and typhoid fever cases for September, 1904, over Sept., 1903, as a fact there were probably much less of both, since the reports received in 1903 did not represent more than two-thirds of the state, whereas in 1904 they cover practically the entire state. In 1903 very few physicians reported typhoid fever, while in 1904 most of the physicians report such cases. In Yakima county there has been a very marked decrease in typhoid fever over 1903, though the report shows a marked increase. This is due to the fact that all cases are now reported, while last year none except fatal cases were reported to this office before October.

ELMER E. HEG,
Secretary.

MEDICAL SOCIETIES.

Name. Meetings Held.

Washington State Medical Association..................1905—Tacoma
President, J. R. Yocum, M. D.; Secretary, A. H. Coe, M. D.

Chehalis County Society . . 1st Tuesday, Jan. Apr., July, Oct.—Aberdeen
President, D. A. Schumacher, M. D.; Secretary, J. W. Scamell, M. D.

Chelan County Medical Society................................
President, W. M. McCoy, M. D.; Secretary, H. A. Saunders, M. D.

King County Society ....First and Third Monday—Seattle
President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D.

Lewis County Society ....First Monday
President, J. T. Coleman, M. D.; Secretary, Charles Harden, M. D.

Pacific County Society ....
.............Third Monday of Jan., April, July, Oct.—South Bend
President, G. W. Overmeyer, M. D.; Secretary, Mary W. Gunwell, M. D.

Pierce County Society.............First and Third Tuesday—Tacoma
President, C. Quevli, M. D., Secretary, A. de Y. Green, M. D.

Skagit County Society ....
President, A. C. Lewis, M. D.; Secretary, R. J. Cassel, M. D.

Snohomish County Society...................First Tuesday—Everett
President, C. A. Mead, M. D.; Secretary, James Chisholm, M. D.

Spokane County Society...................First Thursday—Spokane
President, G. S. Armstrong, M. D.; Secretary, Geo. A. Gray, M. D.

Walla Walla County Society.........Second Wednesday—Walla Walla
President, N. G. Blalock, M. D.; Secretary, Y. C. Blalock, M. D.

Whatcom County Society..................Second Monday—Whatcom
President, D. E. Biggs, M. D.; Secretary, W. N. Hunt, M. D.

Whitman County Socity.........Third Monday of Jan., Apr., July, Oct.
President, W. N. Divine, M. D.; Secretary, R. J. Skaife.

Yakima County Society..............First Tuesday—North Yakima
President, David Rosser, M. D.; Secretary, Carver, M. D.

Oregon State Medical Association ....1905—Portland
President, Geo. F. Wilson, M. D.; Secretary, L. H. Hamilton, M. D.

City and County Medical Society of Portland...First Wed.—Portland
President, R. L. Gillespie, M. D.; Secretary, A. D. Mackenzie, M. D.

Multnomah County Medical Society..........First Tuesday—Portland
President, A. Tilzer, M. D.; Secretary, L. Victoria Hampton, M. D.

Montana State Medical Association 1905
President. B. C. Brooke, M. D.; Secretary, Grace W. Cahoon, M. D.

Silver Bow Medical Society....Second and Fourth Wednesdays—Butte
President, T. J. Murray, M. D.; Secretary, Grace W. Cahoon, M. D.

Idaho State Medical Society............................1905—Boise
President, R. L. Nourse, M. D.; Secretary, E. E. Maxey, M. D.

North Idaho District Medical Society...............June 9—Lewiston
President, C. L. Gritman, M. D.; Secretary, C. D. Parsons, M. D.

South Idaho District Medical Society.........Jan. 5, 1905—Pocatello
President, H. A. Castle, M. D.; Secretary, E. W. Kleinman, M. D.

British Columbia Medical Association...............1904—Vancouver
President, A. P. Procter, M. D.; Secretary, W. D. Brydone-Jack, M. D.

Vancouver Medical Society ....Vancouver
President, W. D. Brydone-Jack, M. D.; Secretary, J. S. Conklin, M. D.

Corrections and additions to this list are requested from societies reached by this journal.

NORTHWEST MEDICINE

December, 1904.

ORIGINAL CONTRIBUTIONS.

THE TECHNIC OF PELVIC OPERATIONS BY VAGINAL SECTION.*

By J. Riddle Goffe, Ph. M., M. D.,

NEW YORK.

Professor of Gynecology in the New York Polyclinic, Visiting Gynecologist to the City Hospital, etc., etc.

I do not know how popular or unpopular the vaginal route of attack in pelvic diseases in women may be in the Southern Surgical and Gynecological Society, how much it may have entered into your deliberations, or whether there be in your ranks so much as one devotee and advocate of the method. However that may be, I am glad to bring you tidings of its continued satisfactory results in my own hands and of its steady growth in popularity and adoption throughout the country. Scarcely a week passes that does not bring me a letter or a verbal report from some former student who has been using the method with marked improvement in his results over his former experience with laparotomy. The most marked example of this is at the St. Joseph's Hospital, in Yonkers, N. Y., in which the entire Visiting Staff of Surgeons—six in all—have as a routine method adopted the vaginal route for pelvic disease to the almost complete exclusion of laparotomy, and with such improvement in their statistics that they are all ardent advocates of the method. These men are, or were, all general surgeons without any special training in gynecology. St. Joseph's is a general hospital with an ambulance service whose range of cases is very wide. But with them every disease confined to the true pelvis in women is attacked through the vagina. A complete report of three years of this work at this institution was recently presented before the New York Academy of Medicine, by Dr. Henry Moffat, and since published.[1]

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*Read by invitation before the Southern Surgical and Gynecological Society at Atlanta, Ga.

[1] —Medical Record, December 5, 1903.

In summing up the subject the author says:

"The following conclusions are fairly indicated, not only from my own personal experience, but from what I believe, a candid study of the table of cases would teach.

"1. The anterior vaginal route is most useful for reaching and operating upon the round ligaments in cases of retroversion of the uterus or procidentia: also for removal of small fibroids, either subperitoneal or pediculated, for conservative work on the ovaries and tubes, or for removal of these organs.

"2. The posterior incision is most useful for drainage in cases of pyosalpinx, salpingitis, pelvic abscess, some cases of tubal pregnancy with hematocele and puerperal sepsis, either with or without involvement of the tubes; for oophorosalpingectomy, when the ovary is held backward and downward by old adhesions, and even in some cases of acute general septic peritonitis.

"The more I see of this work the more am I impressed with the important truth that no pus tube should be attacked by any other route than by the vagina.

"The following are the summaries of the tabulated record of vaginal operations performed in St. Joseph's Hospital by seven different operators during these three years.

"Anterior Sections.—Shortening the round ligiaments for retroversion, 11; exploratory with breaking up of adhesions, 2; myomectomy, 2; resection of ovary, 1; single oophorectomy, 3; double oophorectomy, 2: total, 21 operations with no deaths.

"Posterior Sections.—Single oophorosalpingectomy, 21 double oophorosalingectomy, 8; drainage for (*a*) pelvic abscess, 10; ((*b*) puerperal sepsis, 6; (*c*) pelvic haematocele, 5; (*d*) salpingitis, 2; (*e*) exploratory operations, 2; total, 54 operations, with 2 deaths, giving a mortality of 3.75 per cent.

"Hysterectomies.—Performed for complete procidentia uteri, 7; puerperal sepsis, 3; double pyosalpinx, 3; uterine fibroma, 2; double pyo-salpinx and uterine fibroma, 1; carcinoma uteri, 3; total, 19 cases, with 6 deaths, giving a mortality of 31.6 per cent. The deaths were in cases of puerperal sepsis, 2; uterine fibroma, 2; carcinoma uteri, 1; double pyosalpinx, 1."

In my own hands the scope of the operation, *i. e.*, the conditions to which it is applicable, is steadily widening. It is no longer confined on the one hand to simple puncture and drainage nor limited on the other to the radical operation of hysterectomy. All the intermediate procedures that are called for by the multifarious pathologic conditions found in a woman's pelvis find their most direct route through the vagina.

There are two vaginal incisions through which the pelvic cavity can be reached; one posterior to the cervix into Douglas' pouch, and the other anterior to the cervix, separating the bladder from the uterus and opening up to view and touch the entire contents of the pelvis. The latter is the one which affords the greater facilities for operative procedures, and the one which I depend upon almost exclusively. The posterior incision is frequently used in connection with it to afford additional opportunity for the purpose simply of securing drainage and in some cases for manipulation. Briefly, the procedure consists in making a transverse incision in front of the cervix corresponding to that employed in complete vaginal hysterectomy. Through this incision the bladder is dissected from the uterus up to the peritoneal fold. The peritoneum may then be incised and the peritoneal cavity opened, or that can be left until the next step in the process is completed, which consists in making a longitudinal incision through the vaginal mucous membrane and sheath throughout its entire length. This is accomplished by grasping the edge of this transverse incision either side of its middle point by two artery clamps. Tension upon these clamps puts the anterior vaginal wall upon the

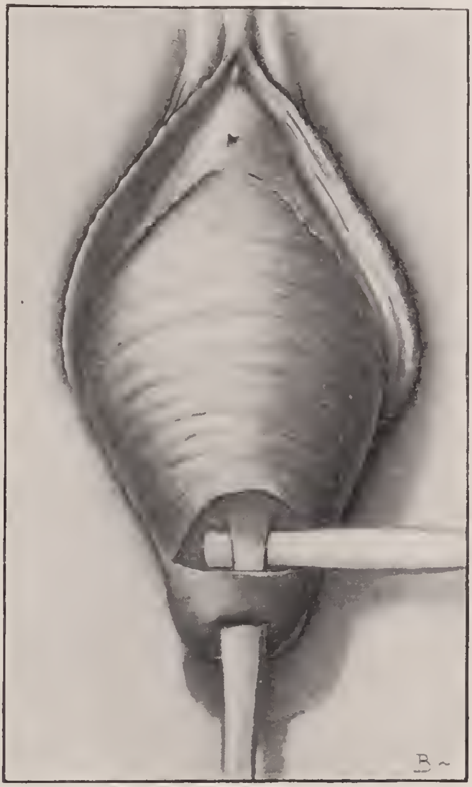

Fig. 1. Dissecting out the utero-vesical ligament before cutting it.

stretch, and an incision is made with the knife from the neck of the bladder down to the center of the transverse incision. The bladder is then dissected off the vagina for the distance of an inch or an inch and a half either side of this longitudinal incision. The purpose of this second incision and the separation of the bladder is to secure sufficient room in which to work. The dissection is done almost exclusively with the handle of the scalpel and the finger, and the hemorrhage is inconsiderable. Through this opening, whether in virgin or multipara, ample space is afforded for whatever radical or conservative work upon the uterus and its appendages may be indicated. This becomes at once apparent when we consider that the vaginal cleft, *i. e.*, the introitus vaginae, is quite as large as the usual abdominal incision of a laparotomy, and by this T incision in front of the uterus the opening into the peritoneal cavity duplicates the size of the introitus.

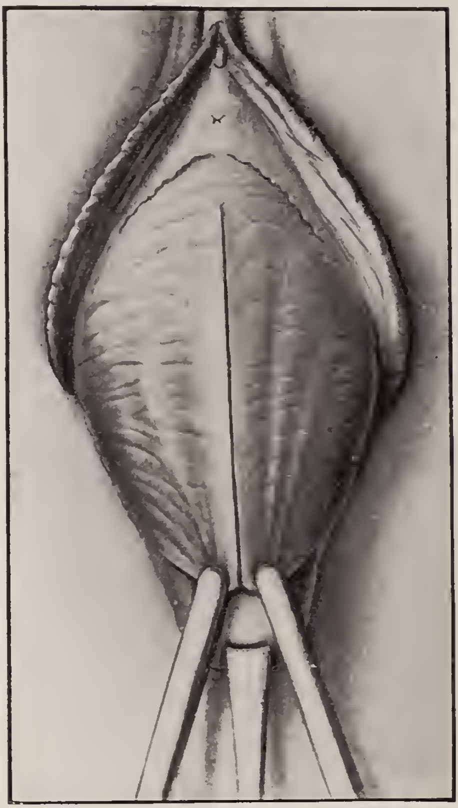

Fig. 2. The longitudinal incision in anterior vaginal section.

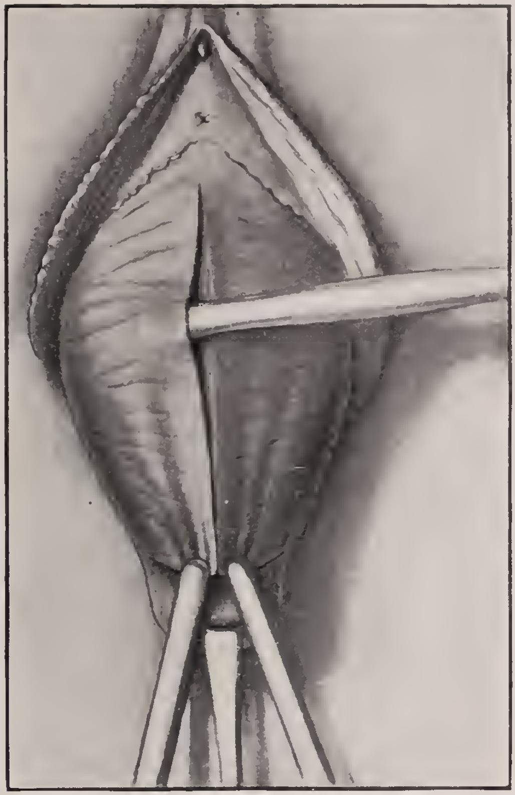

Fig. 3. Beginning dissection of bladder from the vagina.

The simplest and at the same time very important function which is subserved by an incision into any of the large cavities of the body is that of an exploratory operation. An exploratory incision, so far as possible, should be free from danger; should give facilities for gaining the desired information, and at the same time afford opportunity for the completion of such surgical procedures as may be indicated.

The anterior vaginal incision fulfills these functions most satisfactorily. (1) It is free from danger; more than that, it is devoid of any untoward or annoying consequences. When I first began its use I felt that it might be followed by more or less serious bladder symptoms. In this, however, I have been happily disappointed. Indeed, I have yet to meet the first case in which there have been any symptoms following this procedure referable to the urinary apparatus. The tissues through which the opening is made seem to be unusually tolerant of traumatic interference.

and the generous blood supply of these parts favors prompt and complete healing. (2) As an exploratory incision I have found it to afford the means of accurate, definite and reliable information in regard to the entire contents of the pelvis. (3) The third condition is an important one, and experience is constantly widening the field of its application, and demonstrating that it affords ample space for completing almost every surgical procedure that may be indicated.

Pelvic Abscess.—The simplest application of the vaginal method, and the one that probably commends itself most universally to the profession, is incision and drainage of pelvic abscesses. Accumulations of pus in the pelvis may have various locations, depending upon whether they arise from puerperal conditions or the results of infection under the general conditions of life. But whether the pus be in the cellular tissue, in the Fallopian tubes, in the ovaries or in peritoneal spaces between coils of intestine and adjacent tissues, the conservative and at the same time the efficient method of attack is vaginal incision and drainage. Under these conditions the anterior incision is rarely used, the opening being made posterior to the cervix or in the lateral sulci of the vagina. The predominant indication for this procedure is in cases of large pelvic abscesses, especially if the patients are acutely ill or prostrated from long-continued suppuration. Noble, of Philadelphia, says that in this class of cases this procedure gives in his hands a mortality of 2 per cent. as contrasted with one of 25 per cent. or more by abdominal section. There is no question concerning the positive merits of the drainage operation; it is done quickly, does not cause shock to the already weakened patient, and permits her to recover from the critical condition in which she is placed by the accumulation of pus and the general septic condition. Should the ovaries and tubes of both sides be found involved and collections of pus therein, they may be freely opened through the posterior incision and drained. The central incision is made into Douglas' pouch and into that common cavity the various pus pockets are opened. Should the condition of the appendages be such as to necessitate their removal and the vitality of the patient warrant it, they may be removed through the posterior incision or a pan-hysterectomy performed, thus accomplishing what our laparotomy friends call, "a complete operation." In cases in which the appendages of one side show probability of recovery, it is my custom to pack the pelvis through the posterior incision with gauze for the purpose of lifting the intestines out of the pelvis, and to then make the anterior incision, remove the hopeless appendages, washing, cleaning up and disinfecting the appendages to be left. As a rule it is safest in *desperate* cases to simply open into the collections of pus, break up the involved cellular tissue and insert a T drainage tube.

Vaginal incision and drainage has by universal approval taken the place of vaginal puncture. One point in the technic I wish to emphasize, and that is that the incision through the vaginal tissue should be sufficiently free in its extent to afford opportunity for careful investigation with the finger and ensure a sufficiently patulous opening during the succeeding drainage period. The utero-sacral ligaments are such important structures in retaining the uterus in its normal position that I am careful not to interfere with their continuity, and after entrance through the peritoneum into Douglas' pouch prefer to dilate and stretch rather than to cut. The technic is as follows: The cervix is seized with a strong traction forceps and drawn down to the vulva or near to it as possible with reasonable traction. A transverse incision is made with scissors or knife in the middle line through the posterior vaginal wall, close to the cervix, down to the peritoneum. The latter is then caught up with a mouth tooth forceps and snipped with the scissors. Through this opening first one index finger is pushed and then the other and the peritoneum torn and stretched out to the utero-sacral ligaments, care being taken not to injure these structures. In case of hemorrhage the cavity should be packed with gauze and the insertion of the drainage tube postponed till the gauze is removed.

Shortening The Round Ligaments.—The condition in which I first applied the anterior incision was that of retro-position of the uterus, and perhaps it may be well to speak of that first. I am a firm believer in the principle that the uterus is supported exclusively by its ligaments, that when a uterus remains in normal position it is because its ligaments retain it there, and when a uterus gets out of its normal position it is because the ligaments have failed to do their duty. This is indisputably the case in unmarried women who suffer from procidentia or simple retro-displacement. In cases, therefore, of displacement of the uterus, the ligaments and the ligaments alone are the proper tissues to utilize in restoring and maintaining the uterus in its normal position. The success attained by the Alexander operation of shortening the round ligaments at the external ring, and by the Wylie-Mann operation of shortening the round ligaments intraperitoncally, and the multiplicity of devices for utilizing the round ligaments for this purpose is ample assurance of the efficiency of these ligaments for this purpose. In this connection we recall the Kellogg, Dudley, Goldspohn, Gilliam, and many other operations. My plan of procedure consists simply in shortening the round ligaments inside of the pelvis, but I do it through the anterior vaginal incision.

The technic is as follows: After entering the peritoneal cavity, the uterus is dragged down firmly by traction forceps attached to the cervix, and the finger passed over the fundus and slipped along until it hooks over the broad ligaments near the uterus. The round ligament near to its origin from the uterus is then seized between the index finger, which is on the posterior face of the broad ligament, and the thumb, which is anterior. The cervix is now pushed into the posterior fornix and the traction forceps removed, the cornu of the uterus in the meantime being dragged forward and downward into the vagnia. The bladder and vagina are pushed up by a retractor or the index finger of the other hand, and by a little persistent effort the entire uterus is delivered into the vagina. In accomplishing this maneuver I never catch the fundus with a volsellum forceps, tenaculum or other pointed instrument. They break the peritoneum and give a point for future adhesions; sometimes cause annoying hemorrhage. As a rule the fingers are the only instrument necessary. If a little firmer grip is desirable the ovarian ligament near to the fundus may be grasped by a sponge forceps. This ligament is strong and fibrous and affords a very good hold. The round ligament, first of one side, then of the other, is caught by an artery clamp from one to two and a half inches from the horn of the uterus and dragged down in the form of the letter U. A fine, twisted silk suture is now passed through the ligament at a point on the outer side of the forceps and then near to the uterus. The point selected at the outer side of the forceps is at as remote a point as will allow of approximation to the second point through which the stitch is passed near the horn of the uterus. It is then tied, thus shortening the round ligament to an extent equal to the length of tissue taken up in the loop. The two arms of the loop between this suture and the forceps are then stitched together by two sutures of silk, and finally a third one catches the tip of the loop and attaches it to the anterior face of the uterus just at the origin of the round ligament. This latter suture is for the purpose of disposing of the loop of tissue, although it doubtless

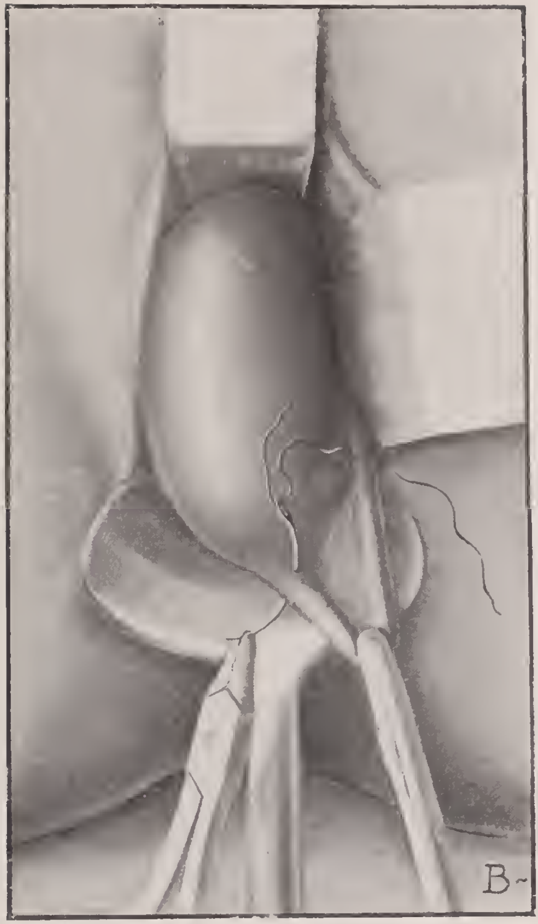

Fig. 4. Shortening the round ligament, first suture.

affords an additional support. The horn of the uterus thus treated is allowed to resume its position in the pelvis. The other horn of the uterus is drawn down and the round ligament of that side treated as in the first instance. The uterus is then allowed to take its normal posture of anteversion in the peritoneal cavity, and the bladder tissue is adjusted to its original position. Two catgut sutures sew up the transverse incision in front of the cervix, and the running catgut suture restores the vagina along the longitudinal incision. The vagina is then packed with gauze and the operation is completed.

Cases of retroversion complicated by adhesions, either of the uterus or of the appendages, are made to conform to this

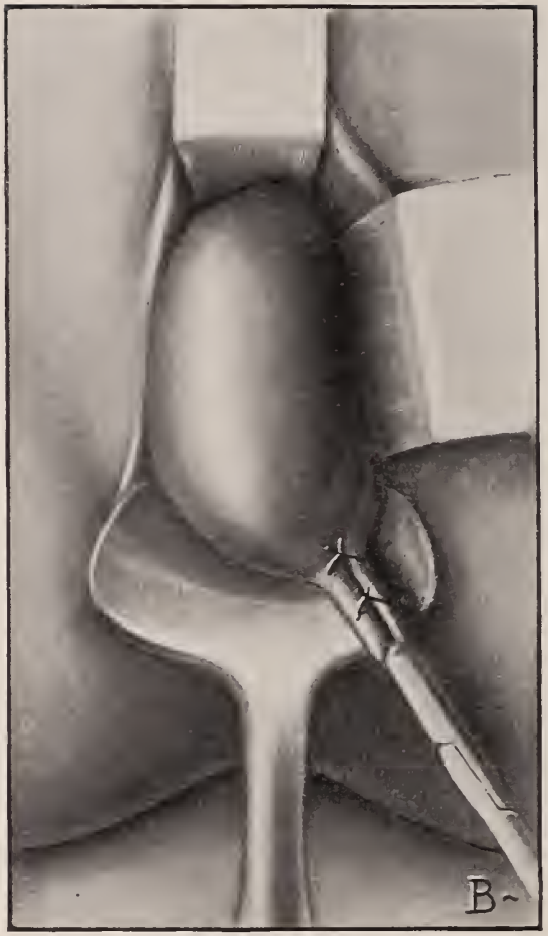

Fig. 5. Shortening the round ligament, first two sutures tied.

technic after the adhesions have been broken up by the finger. Where the adhesions extend to the bottom of Douglas' pouch and are difficult of access, a posterior vaginal incision is made, and through this the separation of the adhesions is completed.

Resection of Tubes and Ovaries.—It is my custom always in these cases, after delivering the uterus into the vagina, to bring down the appendages also, first one side and then the other, and do such conservative work upon them as their condition indicates. This work consists of such procedures as puncturing multiple cysts of the ovaries with a Pacquelin cautery, in some cases resecting portions of the ovaries, at the same time freeing the Fallopian tubes from adhesions, opening up the fimbriated ends, and under a stream of normal saline solution massaging the tubes, squeezing out any retained secretions, probing the tubes to discover their patency or constriction, disinfecting them with pure carbolic or tincture of iodine on a probe, and, when necessary, amputating them at a point that will afford a patulous tube from there on to the uterus.

My work in this department of conservation of tissue and function of the ovaries and tubes in connection with shortening the round ligaments has been most satisfactory. In cases of pyosalpinx where the tube is hopelessly destroyed, the greatest facility is afforded for dissecting out the tube from the horn of the uterus and closing its bed with sutures. The fundus lies in the introitus vaginae where the tube and ovary are easy of access and one or both can be taken off by the angiotribe or by ligature. If the tube is dissected out of the horn of the uterus its bed is closed by suture. My cases illustrate all forms of complications, from the simple removing of diseased appendages through the whole range of conservative procedures to the removal of the products of conception in ectopic pregnancy, dermoid cysts, myomectomy for small fibroids and hysterectomy by morcellation for large fibro-myomatous tumors.

It is a nice question to determine how far active surgical interference is advisable in cases of acute infection of the uterine appendages. Polk, Pryor and Henrotin have advocated and practised opening of the *cul-de-sac* and drainage in cases of threatened or early involvement of the appendages as a prophylactic or function saving procedure. During the past month I have gone a step further and in two cases of acute salpingitis with constitutional symptoms, one of which had reached the stage of pus formation—a tubo-ovarian abscess—and have boldly attacked the disease through both the posterior and anterior incisions.

Case 1.—Mrs. S., the mother of two girls, who six weeks after her second confinement was infected with gonorrhea. Six weeks later she entered one of the large New York hospitals where she was told that the only thing that would cure her was the removal of her uterus and appendages—a pan-hysterectomy. To this she would not consent because, as she said, she wanted a boy baby. She therefore left and through an acquaintance with some of my hospital clientele came to me at the Polyclinic. She had a temperature, 101°, a foul tongue, irritable stomach, a mass as large as one's first involving the left appendages and a large adherent tube on the right side, also an effusive leucorrhea. I told her I thought it very probable that I could save the right ovary and tube if the operation were done promptly, and if I were successful it would be possible to secure her longed-for boy. She consented. The uterus was thoroughly curetted, swabbed with pure carbolic acid and packed with iodoform gauze. The *cul-de-sac* was opened, adhesions gently severed with the finger, and some iodoform gauze carried up to the promotory of the sacrum. Then the anterior incision was made, the balance of adhesions surrounding the inflammatory mass separated and the fundus of the uterus delivered into the vagina. The appendages which were the less involved were then drawn down, the tube found enlarged, inflamed, occluded, the fimbriae being adherent to the ovary. Under an irrigation of hot saline the ovary was washed, the fimbriae were massaged and opened out, the contents of the tube consisting of a few drops of muco-pus was milked out and a silver probe loaded with tincture Iodine carried into the tube its full length. The fimbriae and ovary were also brushed lightly with iodine. These were replaced and adjusted upon the gauze which had been inserted in the *cul-de-sac*. The involved mass of appendages of the left side were then brought down to the vulva, a collection of pus involving the ovary and tube was set free and the appendages removed with the angiotribe, the uterine stump of the tube being dissected out and the horn of the uterus stitched. The uterus was then restored to its normal position, the peritoneum and bladder adjusted, the longitudnal vaginal incision stitched, the transverse incision being left open and the vagina packed with gauze. On being placed in bed she was immediately adjusted to the Fowler position and kept there for several days.

This position is attained by elevating the head of the bed, thus facilitating drainage of the pelvic and abdominal cavities. The head of the bed is raised two and a half to three feet. To prevent the patient slipping down toward the foot of the bed, a sheet attached at both ends to the head of the bed is passed down around the buttocks like a sling, a pillow being placed between it and the buttocks for comfort. The expression of the faces in the illustration indicates how comfortable they are.

Case II.—Miss L., a young hairdresser, who was sent into the hospital by her physician to be curetted for leucorrhea and menorrhagia. She had had a miscarriage a year before. Upon examination under ether it was discovered that she had a retroverted, adherent uterus and double salpingitis. As nothing had been said to her about opening into the peritoneal cavity only curettage was done. Following this she developed temperature and sensitiveness over both ovarian regions and ten days later she was subjected to vaginal section. Old adhesions were firm and extensive over the posterior face of the uterus reaching to the top of the fundus, both tubes were occluded and adherent to the ovaries with collections of muco and sero-pus at the infundibula of the left and right sides respectively. The adhesions were broken up, the uterus and appendages, first of one side and then the other, delivered into the vagina. The fimbriae of the left side were separated from their grip on the ovary, massaged and opened out. On the right the fimbriae were obliterated hopelessly and the tube saculated. The adhesions to the ovary were separated, the sack incised and evacuated. Both ovaries were washed with saline solution and bichloride, the tubes irrigated with the same, using sufficient pressure to dilate them throughout their entire length, and disinfected with iodine on silver probe. Gauze was packed in *cul-de-sac*, draining through the posterior fornix. The round ligaments were shortened and anterior incisions closed. Gauze was also packed in the vagina. Patient placed in bed in Fowler position.

Both patients are making a smooth and satisfactory convalescence. One is in her third week of convalescence and the other in the fourth*.

Anterior colpotomy is used by different operators for accomplishing the relief of displacements in various ways. Duehrsen and Wertheim shorten the round ligaments sometimes by doubling them upon themselves, as I have described, and sometimes by fastening a loop of the round ligament to the vaginal incision. The latter method is advocated by Vineberg, of New York. In certain instances the uterus is attached to the vaginal wall by the method known as vaginal fixation. The dangers of this method, I think, have been greatly exaggerated, and the unfortunate consequences that have followed in the cases reported have undoubtedly been due to an unnecessary and unwarranted extreme anteversion of the uterus. Judgment must be used in determining the point upon the anterior uterine wall at which the vagina should be attached. I frequently put a sustaining suture through the anterior uterine wall, attaching it to the vagina, in cases in which I find undeveloped round ligaments or in which the inflammatory deposit at the base of the broad ligaments tends to hold the cervix forward in the pelvis, thus making undue tension upon the round ligaments.

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*Both of these patients made perfect recoveries.

(*To be continued.*)

CHOREA IN PREGNANCY.*

By J. M. Semple, M. D.

Spokane, Wash.

It is not the part of this paper to consider Sydenham's chorea as it affects children but, as the etiology, symtomatology, pathology and treatment, in part, are so similar to those of chorea in pregnancy, they cannot well be separated. There is a vast difference in the prognosis and on that account this subject will be of interest to all practitioners. It is rare, indeed, that death occurs in chorea in childhood, while the death rate in chorea in pregnancy varies from 17 to 36 per cent.

As in chorea affecting children, anemia, heart disease, rheumatism and other infectious diseases are frequently predisposing causes of chorea in pregnancy. Trauma, fright and shock are not so frequently given as causes in the latter disease although anger in excessively irritable and hysterical women is more common. F. S. Newell, in the *Boston Medical and Surgical Journal*, of April, 1901, claims the modern belief is that chorea in pregnancy is of nervous origin and that it may be considered a neuresis, due to the irritation of the utero-ovarian plexus in a considerable portion of cases. On the other hand, many contend that infection is the sole cause, while many follow Kirke's claim that the disease is always secondary to an endocarditis with resulting embolism of the smaller cerebral arteries. While it is true that endocarditis is found more frequently than any other lesion associated with chorea, and that in fatal cases autopsies have frequently disclosed such vascular changes as embolism, thrombosis, and minute hemorrhages with exudation of leucocytes and areas of softening, yet these symptons are wanting in others. The same is true of infectious diseases. There are cases of chorea that occur without the slightest evidence of a preceding or accompanying infection yet the train of systoms are very similar in all. In Koester's study of 121 cases 35 showed no infectious etiology, and in one of my cases, to which I will hereafter refer, no history of infection could be ascertained. In chorea in pregnancy this much may be said in favor of the theory of infection, that the disease in the majority of cases occurs for the first time in primiparae: and it is well known that the first pregnancy is more subject to infection than later pregnancies. I believe there is a subsoil of inherited predisposition to the disease in some cases that may require nothing more than the irritation of the utero-ovarian plexus, caused by the marvelous changes induced, especially at the first pregnancy, to bring forth the train of symptoms known as chorea. We know what disastrous effects on the mind are brought about by pregnancy and lactation in some cases without infection and we have every reason to believe that the motor as well as the psychical centers may be involved from such a cause. I think we can safely agree with Osler that we are still far from a solution of all the problems connected with chorea.

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*Read before the Washington State Medical Association, Seattle, Wash., July 12-14, 1904.

The *symptoms* of chorea in pregnancy differ mainly in degree from chorea in childhood. They may appear any time from conception to the ninth month but are more frequently found during the first three. The later they appear, unless as a secondary attack, the more dangerous they are. If, however, pregnancy occurs in a choreic individual, whether the attack begins soon after conception or later, it is likely to be of light form and easily controlled.

In chorea of pregnancy the interference in speech, deglutition and sleep are usually much more marked than in chorea of childhood, and the mental disturbance more often takes the form of mania which is very exhausting. In the chorea of childhood there is usually mental obtundity resembling acute or primary dementia which passes away without so much exhaustion. This may account, in a measure, for the lessened mortality in the latter disease.

The high mortality in this disease makes it one of the gravest, if not the most grave, complication we have to contend with in pregnancy. Buist collected from the literature on this subject 255 cases with a mortality of 17.5 per cent.

The mortality in Shrock's 154 cases was 22 per cent. while the death rate of Fehlings' cases was 36 per cent.

The *treatment* of chorea in pregnancy is that of chorea in childhood with the question of induced labor added. Mental and physical rest are the most important requisities and, in fact, the keynote to the treatment of all forms of acute chorea. Without it all other means are likely to fail. Cases of infectious etiology should have the specific treatment required for the various predisposing affections. As nearly all cases, whether infectious or not, have more or less marked anemia, such alteratives as arsenic and iron are of great service. Arsenic has been found to be of value in almost all cases except those which are intolerant of that drug and those very acute cases accompanied with coma or paralysis. Another class of cases that does not take arsenic well are those where the rheumatic process is in an acute form with high temperature, joint pains and endocarditis. To allay great nervous irritability and promote sleep the bromides and chloral are of great benefit and when these fail morphia phyodermically, either alone or in connection with the above remedies, may be required. The diet should be unstimulating and easily digestible and chief among such foodstuffs is milk. Eggs with a little toast or zwieback may be added; and as convalescence is becoming established the various nitrogenized articles of food may be gradually added, and increased in quantity. Tea, coffee and other stimulating liquids should be rigidly interdicted. When convalescence is fairly well established purposive muscular movements should be encouraged to hasten the return of normal nerve function. Prolonged muscular or mental strain should be carefully avoided for some time after recovery has apparently taken place. Relapses sometimes occur when the ordinary routine of life is resumed too soon after the disappearance of objective symptoms, and their recurrence tends to form the choreic habit which is likely to incapacitate the patient from the active duties of life.

The question of emptying the uterus is a serious one in chorea of pregnancy. Jolly recommends abortion in all aggravated cases. Zweifel goes further and advocates emptying the uterus as soon as the diagnosis is made. A few fatal cases, I imagine, might lead almost any of us to follow Zweifel's advice but I think the average practitioner will take more kindly to Jolly's and operate only in the aggravated cases that offer no other hope. In this connection I might say that there is danger in waiting too long. When the patient is thoroughly exhausted the trials of labor over-tax the already weakening nervous system and death from exhaustion occurs sooner than if left alone.

Chorea in pregnancy is fortunately an uncommon affection. According to statistics it occurs about once in a thousand pregnancies. Several of you have have had a number of cases and many perhaps not any. I had not seen a case from 1887 until last November and since then I have had a second. A brief history of those two cases I shall now give:

Case 1.—Mrs. S. M., a Norwegian, aged 24, who had been married three months, first came to my office early in November, 1903. She had become pregnant soon after her marriage as no menstruation had occurred since then. About a week or ten days before that visit a slight jerking was noticed in the left arm, which gradually spread to the left leg and face. On examination there was a noticeable weakness and slight inco-ordination of muscular movement of the right side as well. She was urged to go to the hospital but refused and insisted upon going to her home some 25 miles distant in the country.

The patient had always been strong and healthy, had never suffered from infectious or other diseases, and her family history was perfect so far as I could ascertain. She was an indefatigable worker, somewhat willful by nature, and refused to stay in bed as directed. A week after she went home a neighbor called and said the patient was steadily growing worse, was more sleepless, and refused to stay in bed much of the night as well as the day.

On Nov. 25th, she was brought to the hospital. Her condition was greatly aggravated, and jerking was bilateral and very violent, speech and deglutition were markedly interfered wth, and there was a decided tendency to mania. She was put to bed, her diet consisted of milk and egg nog, and antipyrin and sodium bromide ordered. The urine was normal in quantity but showed a slight trace of albumin without casts. She did not sleep at all the first night, and during the second day had only brief naps not amounting to more than one hour altogether. Although 20 gr. of choral were added to the bromide the second night no sleep resulted. On the morning of the 27th her temperature, which had been normal, rose to 102.6° but soon fell after a tub bath had been given. At bed time, on the 27th, she was given morph. sulph. gr. $\frac{1}{4}$ and atropin sulph. gr. 1-150, in addition to the bromide, and she had two hours sleep which seemed to strengthen her temporarily. The following morning she was more quiet but during the day the clonic spasms became more violent than ever and it became necessary to restrain her to keep her from falling out of bed. The urine and feces were now avoided involuntarily. A consultation was held and empting the uterus decided upon. The usual antiseptic precautions were observed and a sterile catheter introduced into the uterus on the evening of the 28th, which was followed by a miscarriage next morning, at 8:30. The fetus appeared to be of between four and five months development.

For a few hours after delivery the patient seemed more quiet but also more feeble both physically and mentally. She had more difficulty in swallowing, and muttered unintelligibly. Muscular jerking continued to gradually lessen, due to the utter exhaustion, and the patient died at 2 p. m., December 2.

Case 2.—Mrs. R. M., American, of German extraction, aged 18, wes married April 4, 1904. Had menstruated once after marriage. Was fairly well developed physically, had always been of high nervous temperament, emotional, with hysterical stigmata fairly well marked. Her father was a man of violent temper and subject to alcoholic excesses. There was nothing abnormal in the other members of the family as far as I could ascertain. About 4 or 5 months previous to marriage the patient suffered from a severe attack of inflammatory rheumatism, but had apparently recovered.

I was first called to see the patient April 30, 1904. The jerking was bilateral and quite violent and there was some difficulty in articulation which greatly annoyed the patient. There was a systolic murmur over the mital valve, and a slight trace of albumin in the urine but no casts. When told she must stay in bed the patient became greatly angered and defiant and then had a crying spell.

In view of the rheumatic history she was placed upon sodium salicylate and the oil of gaultheria. This treatment was continued with apparently good effect for five or six days, the patient sleeping well and taking a fair amount of nourishment. Then the symptoms began to increase and the antirheumatic remedies were discontinued and antipyrin substituted. No improvement occurred and that medicine was changed to sodium bromide with elixir valerianate of ammonia, with temporary improvement Fortunately thus far the patient had slept well. On the 18th she became quite restless and arsenic in increasing doses were given, in addition to the bromide and valerian mixture. No improvement occurred, but on the contrary the patient became more restless and emotional, and her sleep was, at times, disturbed. A consultation was held and abortion decided upon. The uterus was emptied on the 26th. The arsenic was continued after labor and improvement was rapid and uninterrupted.

The difference in the result of the two cases I believe was due to the fact that one did, although reluctantly, follow the advice given her, and the other did not; and that one had relief afforded before complete exhaustion had taken place.

The perils of chorea in pregnancy are so great that I feel impelled to again urge that when the symptoms increase, in spite of medical and moral treatment, and the sleep is becoming disturbed, the only course left for the physician is to induce premature labor which I firmly believe will give the patient the only chance of recovery.

A PRELIMINARY REPORT OF RESULTS WITH EXTRA-VISCERAL LIGATURE IN ENTERO-AND GASTRO-ENTEROSTOMY.

By R. C. Coffey, M. D.
Portland, Ore.

Soon after the McGraw ligature was brought to the notice of the profession, Weir very aptly suggested that an opening between two hollow viscera would be better and more permanent, if it could be

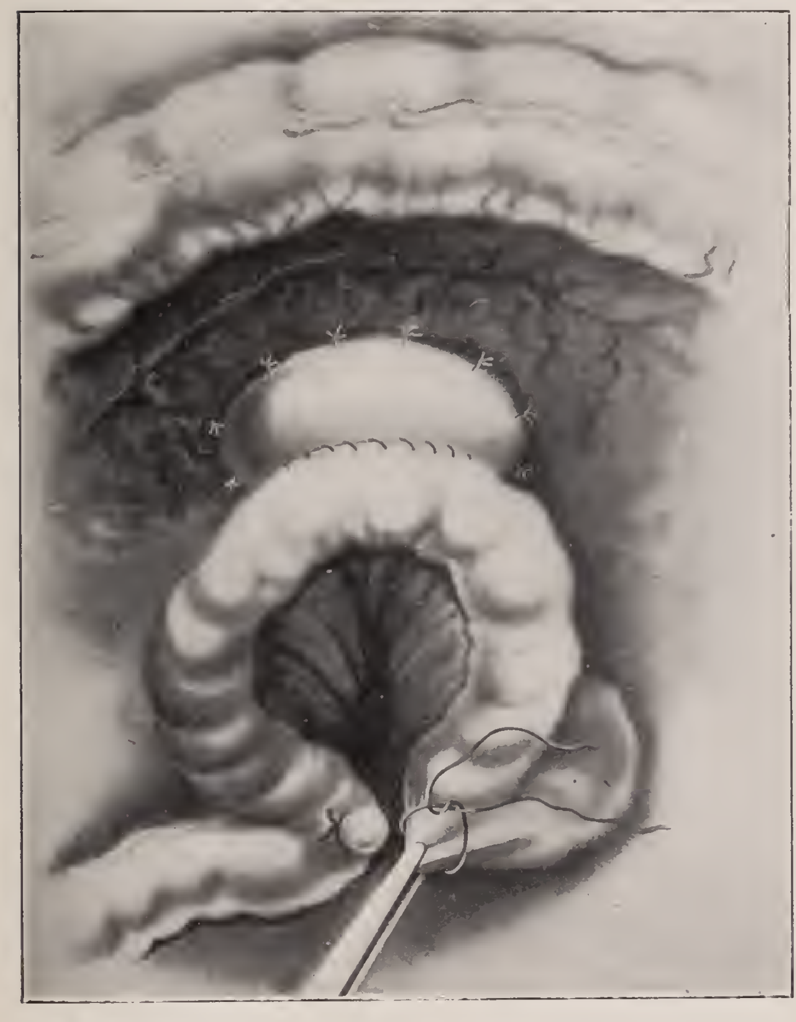

Fig. 1. Gastro-enterostomy has been performed. Knuckle of one intestine tied off, the other being tied.

made in the form of a hole, like that punched through leather in harness-making, than the simple slit made by the McGraw ligature. In my experimental work about four years ago, I noticed that a better opening was left after an operation for lateral anastomosis in which a circular or oval piece of intestine had been cut out than when a simple slit by the ordinary method had been used. The method of cutting out this piece of intestine was shown in the *Medical Sentinel*, in August, 1900. At the last meeting of

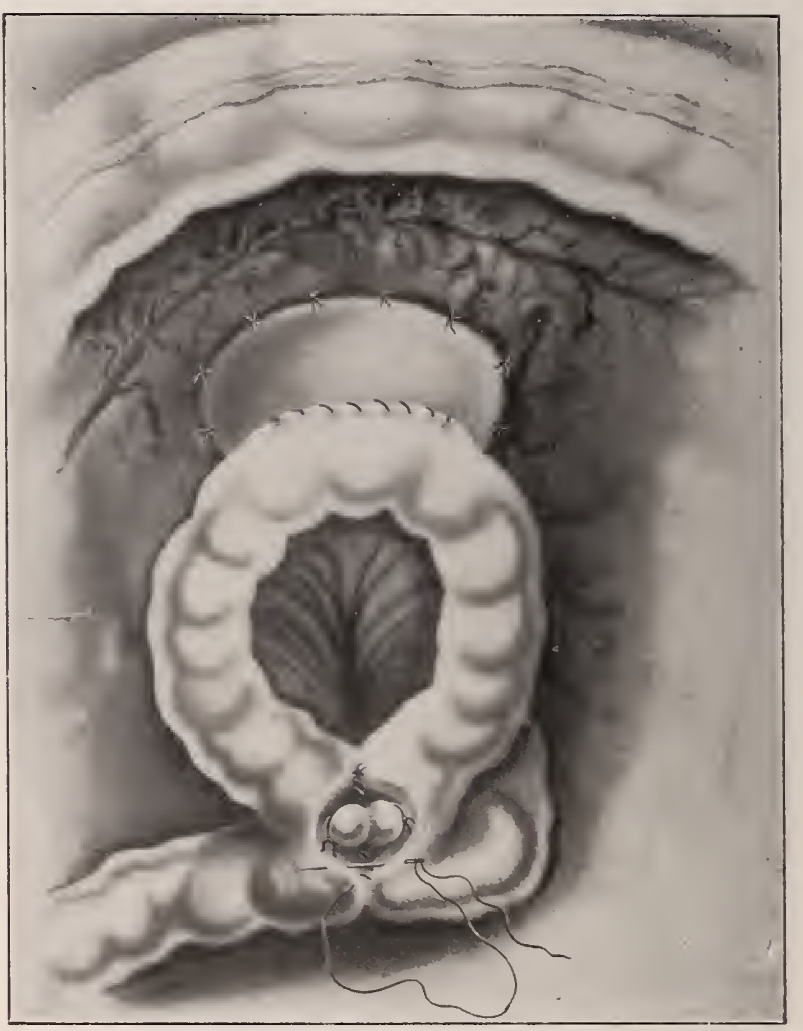

Fig. 2. A continuous Lembert suture has been placed half way around knuckles. Suture being completed as indicated by needle.

the Washington State Medical Association, I was asked to open the discussion of Dr. C. A. Smith's paper, on the use of the McGraw ligature. This caused me to study the principles of the McGraw ligature operation more thoroughly than I had before, and

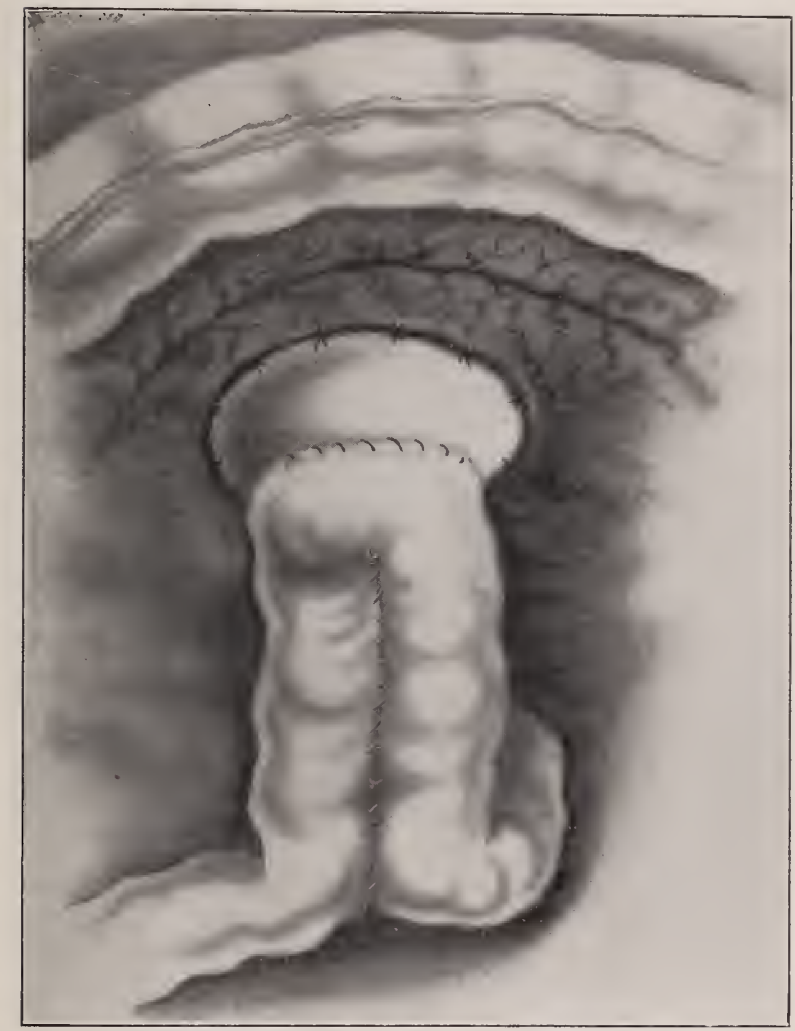

Fig. 3. Enter-enterostomy completed. Loops of jejunum brought together between gastro- and entero-enterostomies.

my conclusion was that it was not an ideal operation, and in the discussion I suggested the picking up of the side of each intestine entering into the anastomosis and tying it off with a strong silk or linen thread, including as much of the intestine as necessary to make a hole of the desired size. Then take a Lembert suture and sew the intestines together, surrounding the two portions of intestine entirely with the suture, as shown by the accompanying cuts.

Early in September, of this year, I was visiting Dr. A. A. Kerr, in Salt Lake City, when he asked me to operate upon a patient of his for "vicious circle," who had had a gastro-enterostomy performed a few months before with excellent results except that the bile and pancreatic juice went into the stomach and kept the patient constantly vomiting until she had become completely exhausted. We first made an entero-enterostomy by Connell's suture method, but found that the location of the opening was not just as we wished. As the patient was very weak, we did not feel justified in doing another enter-enterostomy by the ordinary method, so I spoke to him about the possibility of this ligature method, stating that it could do no harm and could be very quickly applied. So we did it, and at last reports from him the patient was doing well.

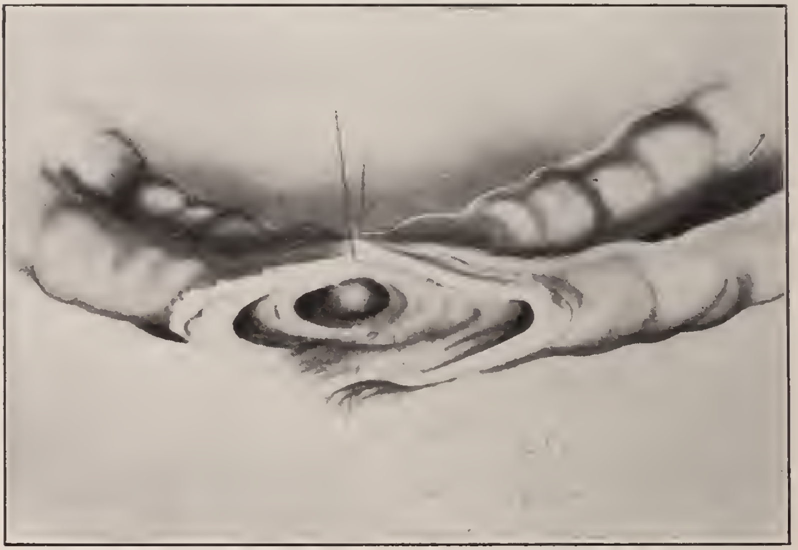

Fig. 4. Dog intestine two weeks after entero-enterostomy by extra-visceral ligature. Opening shows between the two intestines.

Since that time, I have been doing experimental work upon both hogs and dogs along this line, and the work has been so entirely satisfactory and the opening so perfect that I have decided to picture one of the specimens in this preliminary article. This specimen was taken from a dog two weeks after an operation for gastro-enterostomy by the now generally used continued suture.

accompanied by an entro-enterostomy between the two limbs of intestine, by the method described in this article. In addition to the entero-enterostomy, we brought the parallel surfaces of the two intestines together, between the two anastomoses, with a continuous suture, to avoid any possibility of hernia. The drawing is taken exactly from the specimen. The hole here shown is practically the same size as the piece of intestine included by the ligature.

Of course, two weeks does not give time for the passing of judgment as to the amount of contraction which will take place but, taking the matter from a purely theoretical standpoint, it would seem that very little contraction would take place by the passing of time. I am experimenting upon a number of animals to test the practicability and applicability of this operation.

If it can be applied as successfully in gasto-enterostomy as in entro-enterostomy, it certainly should be of value in intestinal surgery; first, because no viscus is opened at the time of the operation, hence no danger of infection; second, the opening may remain patent without distorting or disturbing the normal relations of the muscular fibers of the viscus. This, I believe, is proven by the fact that the opening made by the Murphy button is more permanent than the other metods of anastomosis. I do not recommend this operation in the place of others at the present time, and will not until I have completed and received results from a sufficient number of experimental operations to cover all the points that give definite proof of its value. When more of the animals upon which I am operating have lived a sufficiently long time to test permanent results of the various phases of the operation, I hope to present them in the same manner as the specimen here shown. It would seem that the operation may be applied in all the cases to which the McGraw ligature has been applied which would include gastro-enterostomy and entero-enterostomy and would be especially applicable in the operation which McGraw describes in the November Annals of Surgery, under the title, "A New Operation for Intestinal Stenosis," owing to the fact that the large intestine is a very dangerous organ to puncture even with a ligature.

HEART FAILURE DUE TO ACUTE INDIGESTION.*

By L. R. Markley, M. D.

BELLINGHAM, WASH.

In reading you a paper upon the above subject, I will not burden you with a long discussion upon the mysteries of digestion, the formation of the various ptomains, toxins, leucomains, etc., that are the cause of so many acute cases of autotoxemia. This is a question still unsettled. The early recognition and prompt treatment of this dangerous condition concerns us more than the chemistry of the case. We will, therefore, enter upon the clinical features of the subject.

Some six years ago I was called at midnight to see Mr. L., age 60. The day previous he called at the office to have me examine his heart and lungs; he wanted to know if he was sound. These organs were healthy. I found him tumbling about on the bed with great abdominal pain. He had vomited a time or two. For their supper he and his wife ate freely of pickled smelt. His wife was not affected. I at once gave him a hypodermic of morphia, gr. $\frac{1}{4}$ and atropia gr. 1-150. and took a seat at his bedside In perhaps 10 minutes I asked him how he was feeling: he replied that he was still in considerable pain and that he felt a peculiar numbness in his hands and feet. The next instant I noticed a peculiar expression pass over his face: the eyes rolled up and a tremor passed over his body. I sprang to his side and felt his pulse; there was none; there was no further movement of the body at all. I at once brought my hypodermic into active use and gave him large and repeated injections of glonoin. strychnin and digitalin. It was without avail: he was dead: died instantly and without a struggle.

He gave a history of having had several previous attacks which they had called "bilious spells." The pickled smelt was probably the exciting cause. but why it did not affect his wife is another question.

Four years ago I was called early in the morning to see Mr. H.. age 65. He was taken with severe cramps and running off of the bowels at midnight. While going to the toilet he fell to the floor. I found him in a state of collapse; he presented a picture of severe shock. Ordered hot water bottles placed around him, while I gave him hypodermic of glonoin, strychnin and digitalin, with a little morphin to alleviate the pain. In a very short time reaction set in, his pulse became stronger. color got better, and the numbness of the extremities disappeared. I left him some tablets of the above heart stimulants to take during the day. It was several days before he recovered his usual health.

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*Read before the Washington State Medical Association, Seattle Washington. July 12-14. 1904.

He afterwards went to California, had another attack and died in about 24 hours. His family received a report of the case from the attending physician, which shows that he fell into the hands of a skillful man, and received the best of medical attention. He gave a picture of severe collapse. This man was a dyspeptic.

The next case I will report is the writer himself. A couple of years ago while in San Francisco doing post-graduate work, I ate a late lunch at one of the hospitals after clinics. As I had had my regular 6 o'clock dinner, I ate very sparingly. Returned to my room shortly before midnight. Some three hours later I was awakened by horrible dreams. My body was covered with a profuse perspiration, *but warm.* My pulse was running wildly, least 150, and weak. My bowels were in a great uproar but not much pain. I realized that I was in a serious condition. I was obliged to go to the toilet, which was bad with my heart so weak. Had a very copious stool which was in a frothy condition. I awakened the landlady and asked her to call Dr. Hall who had rooms in the same building. The doctor responded at once and immediately gave me a good dose of glonoin. Soon my pulse began to drop; in an hour it was 120 and stronger. Had another copious stool. In another hour pulse was 100 and by morning 85.

The liberal use of glonoin and the free action of my bowels so soon after lunch are responsible for my being here today. I was not nauseated at all. I did not feel entirely right, however, until I took an emetic of ipecac and salt in a glass of warm water. After washing out my stomach with four or five glasses of warm water, "Richard was himself again." Dyspepsia is a family trait.

Mrs. B., age 40, has for years been subject to occasional attacks of sick headache. They always begin early in the morning, and in an hour or two she begins to vomit. Upon several occasions her heart has almost ceased beating, and only by the timely use of glonoin in large doses has she been saved. Now she keeps a tube of glonoin tablets on hand, and when she feels her heart is going to give trouble, a tablet or two brings her pulse and color up with a bound. She does not always have heart failure with her bilious attacks. She is also a dyspeptic of the flatulent kind.

Last fall I called to see Mrs. L., age 65. She had fainted shortly after breakfast. Found her sitting in a chair, very pale, pulse almost imperceptible, skin cold. Placed her in bed with hot water bottles, gave her a tablet of glonoin on the tongue. Getting no effect from this in 10 minutes, I was about to give her another when she said: "I am going, it is so dark." Her pulse failed completely. I hurriedly gave her a hypodermic of glonoin, strychnin and digitalin, from which we got results in five minutes. In

15 minutes pulse quite strong. Then she became nauseated and vomited considerable ill smelling and poorly digested food. She took a tablet of glonoin and strychnin every hour during the day.

I have for a long time carried a combination hypodermic tablet consisting of glonoin, gr. 1-100, digitalin, gr. 1-100 and strychnin, gr. 1-50. I never administer an anesthetic without having these tablets handy. They are so far ahead of whiskey, hypodermically, that once used you will never be without them.

The various theories advanced as to the causes of these heart failure cases leave the question still in doubt. That there is a powerful and complex poison generated is, I think, admissible. All patients are not affected alike. Children are especially prone to convulsions, but I saw a small child last summer who was in a state of collapse inside of half an hour after the first symptoms of gastric trouble appeared, who was vomiting a lot of indigestible food. I gave her minute doses of glonoin in hot water, with the result of soon bringing up a good pulse and color.

Ptomains are poisons supposed to have been formed by bacterial or chemical action in our food before eating. Hence several persons are usually taken sick at the same time. Leucomains on the contrary are poisons supposed to be formed in some part of the intestinal tract because of faulty animal metabolism. Not all ptmomains or leucomains are poisonous. Just why and how these powerful poisons are generated is still to be settled. How to prevent their formation is still more important. The treatment for these cases I have indicated above in the several cases submitted.

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MORTALITY FROM TYPHOID.

According to Osler, the typhoid mortality in private practice is from 5 to 12 per cent; in hospital practice from 7 to 20 per cent. In the Spanish-American war it was as low as 7 per cent. In discussing this subject at the meeting of the Washington State Medical Association, in Spokane, Dr. Vaughan called attention to the fact that nearly all the vital statistics, published by the State Boards of Health, regularly present death rates from 15 to 30 per cent. He addressed letters to many hundreds of physicians, asking their mortality in private practice, and found it to average about 6 per cent. The only explanation for the high percentage in the published statistics is that the cases have been only partially reported while all the deaths are necessarily a matter of record.

Some instructive facts are obtained in this line from a study of the statistics of the Washington State Board of Health of this year and last. The law requiring a report of all contagious diseases to be made to this Board went into effect July 1, 1903. Prior to this date practically no reports were made, returns beginning during August. For the remaining five months, 654 cases of typhoid were reported, with 83 deaths, a rate of 13 per cent. That anything like complete reports came only from small towns and the rural districts is demonstrated from the statistics of the three largest cities. Seattle recorded 64 cases and 22 deaths, a mortality of 34 per cent; Spokane 69 cases and 23 deaths, 33 per cent; Tacoma 21 cases and 6 deaths, 28 per cent.

During the first ten months of 1904 some general improvement is to be noted. A total of 995 cases have been reported, with 120 deaths, a mortality of 12 per cent. Seattle has recorded 148 cases and 33 deaths, 22 per cent; Spokane 66 cases and 29 deaths, 44 per cent; Tacoma 114 cases and 22 deaths, 19 per cent.

The most instrutive lesson is obtained from the experience of North Yakima. Considerable comment arose on account of the typhoid epidemic in that city during the summer of 1903. The State Board of Health adopted vigorous measures to certify the cases and to check the disease. During the latter five months of the year 192 cases were recorded, this number being admittedly much below the true figure. Deaths were 23, giving a mortality of 12 per cent. This year a strict record has been maintained with the result of 158 cases reported and 8 deaths, a mortality of only 5 per cent. This is probably the only city of the state that offers accurate vital statistics of the disease at the present time.

Based alone on these data one might draw very erroneous conclusions concerning the sanitary conditions of these cities, the existing type of the disease or the skill of the profession in treating it. It would seem that civic pride would impell the medical profession to correct such a deadly record as is here disclosed, which is monthly published to the world and stands as authentic. It is almost superfluous to call attention to the remedy, that has been so frequently drilled into us, the reporting of every case of typhoid to the local health officer. Since each phycisian alone is aware of the cases which he treats, with him rests the reponsibility of proving the unexcelled sanitary conditions which truly exist in our state. We urge careful attention to this matter on the part of all our readers.

KNOCK-OUT DROPS.

The fact is well known that liquor, properly prepared for that purpose, is often given to prospective victims, in disreputable grog shops, with the object of producing unconsciousness leading to easy robbery. The daily paper frequently presents the story of a night's debauch, where the unfortunate drinker remembers nothing after the first glass till next day he finds himself in unfamiliar surroundings and all his money gone. There is nothing to indicate how many police cases of supposed death from alcoholism may have originated in this manner. The consideration of the subject is timely in view of the numerous saloon robberies recently reported in Seattle and other cities of the northwest.

Hubert C. Carel presents an instructive paper on this subject, in *The St. Paul Medical Journal* of June, under the title, Homicide by Picrotoxin Poisoning. He states that the drug commonly used for this purpose is picrotoxin, the active principle of Cocculus Indicus. Heretofore this has been ignored by the toxicologists as an obsolete drug, its chemistry being undeveloped and its physiologic actions little known. The shrub is indigenous to India, the fruit being a small kidney-shaped berry, known as Levant nut, fish berry and knockout drops. It is commonly added to liquor as "extract of hazel nuts." He describes its chemical characteristics and physiologic actions, with important tests for picrotoxin. He states that poisonous doses present symptoms similar to those from strychnin. convulsions being followed by paralysis, delerium and coma. But the symptoms appear to be influenced by the presence of alcohol and. in moderate dose, resemble the latter greatly but are followed by prolonged stupor and unconsciousness. Autopsies were held on three bodies where suspicious circumstances attended the deaths, from all of which picrotoxin was isolated, thus leading to prosecutions and convictions for homicide. As the writer truly suggests, it is appalling to consider the possible results of the reckless use of so powerful a drug in the hands of saloon bandits, where its administration can be so easily concealed. These facts should be especially considered by physicians and public officials who come in touch with this class of patients, and the possible commission of such a crime be held in mind.

OUR CLUB OFFER.

We wish to call the attention of the physicians of the Coast to the unusual offer presented to them of obtaining, at a reduced price of subscription. two of the leading journals of the country, in connection with a subscription to NORTHWEST MEDICINE. None of us needs an introduction to *Annuals of Surgery* or *American Medicine*. They are representative publications, of a character that every physician needs to read in order to keep abreast of the times in matters pertaining to his professional work. At this season, when plans are being made for ones medical journals for the New Year, it is a timely suggestion that our offer be considered as explained at length in the circular which has been mailed to every physician on the Pacific Coast.

TO OUR READERS AND CONTRIBUTORS.

All material for publication must be received by the twentieth of the month preceding publication. Articles will be illustrated by half-tones or etchings when accompanied by photographs or drawings for the same. Reprints of contributed articles can be obtained at the cost of publication, from the Metropolitan Press, publishers of the journal. A limited number of additional copies of the journal will be supplied to contributors, if a request is made for them.

TO ADVERTISERS.

We wish to call attention to the fact that Northwest Medicine has no department for reading notices, publishers' notes, etc., and that the reading matter and advertising pages are entirely distinct.

OBITUARY.

JAMES BEATON MACGREGOR, M. D.

Dr. MacGregor was born at Clinton, Iowa, September 14, 1871. He moved to Pueblo, Col., in 1880, where he attended the public schools till seventeen years of age. For two years he was employed in Stearns & Rogers Mechanical Works, followed by three years as a plumber and another three years in the U. S. postoffice. Then he concluded to study medicine and entered the Hahnemann Medical College of Philadelphia, where he graduated four years later, in 1901. He came at once to Ballard, Wash., where he soon made many friends and established himself in practice. He was twice elected Health Officer for the city, as well as being deputy Coroner. During the past summer he went East to pursue medical studies. He was on the way to Pueblo, with his fiancee, the 7th of August, when they were both killed in the disastrous wreck on the Denver & Rio Grande railroad, due to a flood washing out the bridge at Eden, Col. He was respected and beloved by a large circle of friends and had the promise of a bright future.

COMMITTEE ON PROPHYLAXIS OF VENEREAL DISEASES.

Report Presented to the Washington State Medical Association at Seattle, July 12-14, 1904.

We believe, as our investigation has shown, that the prophylaxis of venereal diseases is one of the greatest problems that the science of medicine has to solve, as no other diseases are so destructable to economic, moral, social and racial conditions of the people.

In Prussia it has been approximately determined that among communicable diseases, typhoid represents a yearly money loss of 8,000,000 marks, about $2,000,000, while the increased expenses and the decreased incomes caused by venereal diseases amount to 90,000,000 marks yearly—an amount which supersedes that caused by consumption.

The above is given to illustrate the economic side of this question. Its national importance is evident from the following: Gonorrhea in women will, according to Schenk, cause sterility in approximately 43 per cent. of marriages. In 100 marriages, Jaquet found sterility caused in 61 per cent. by gonorrhea; in 25 per cent. the husband was the direct cause, and in fourteen cases stenosis of the os uteri was present. Lier and Asher calculated, in cases where both parties were examined, that the husband contributed 59.1 and the wife 40.9 per cent. to the sterile condition.

In the percentage of barren marriages mentioned is to be found a natural, though not so voluntary a cause as abortion, for the apparent "Race Suicide" that is causing governmental officials concern lest, from depopulation, we can not attain future success as a nation and people.

We consider that the government should officially recognize the seriousness of venereal disease, at least in the army and navy, and take some action, considering that venereal prophylaxis is essential to maintaining our national defenses.

The following extracts from a book entitled "Army Inefficiency and Its Greatest Cause," by A. C. Profeit, B. M., are given in order to prove the necessity of such action.

The table to follow shows the average strength of the British Army in each year, with the number of admissions to hospital and the average of men constantly sick with venereal disease.

	1896.	1897.	1898.
Average strength of troops	203,145	198,294	202,166
Admission of venereal	60,627	55,614	46,761
Average daily sick	5,752	4,956	4,057

And the above figures do not include those suffering from sequelae of venereal diseases as rheumatism, diseases of the nervous system, etc.

To estimate the amount of money these diseases cost the country annually is exceedingly difficult, and no exact estimate could probably be arrived at. The difficulty will be apparent when we note the various things that have to be taken into account. For example, there is the upkeep and maintenance of hospitals, the cost of drugs and surgical appliances and the cost of food. In addition to all this there is the loss entailed by the men being rendered unfit for work while in hospital. On the whole, it is probable that 60 cents a day is a fair estimate of what a venereal patient costs the country. However, some intimately acquainted with the subject place it at more, others at somewhat less, and in estimating the cost at 60 cents a head a day, we merely strike the average between the two extremes. Assuming this estimate to be fairly correct, and remembering that the average daily sick for the three years under review amount to 4,921 men, the cost at 60 cents a head per day for these patients amounts to $16,150 a day, or to $2,244,750 per annum, or to the enormous sum of $6,734,250 for three years. The cost of a private soldier of the infantry is about $265 a year; consequently, the sum that is annually expended on these preventable diseases would maintain about 8,500 healthy and efficient soldiers for one year. And the tax payer is willing to permit this waste of money and loss of time.

That we have the same problem to deal with in our army and navy, members of the medical branches of these services will tell you. That our government has not taken practical cognizance of it we know.

And in not doing so, in estimating our full war strength, we are doing it only on paper. The actual disadvantages to a nation, of war strength on paper, past wars and a present one demonstrate.

Moreover, in our army we have the short service system, and thousands of men annually return to civil life and many of them will be syphilitic. The consequences of the marriages that are apt to follow are only too well known to physicians.

Reliable statistics as given above and personal experience, cause us to recommend to this Association, in as much as each state has its sovereign and independent government and is at liberty to settle this question as it deems proper, that this committee be made permanent to co-operate with the committee of American Medical Association, and like committees in other states, to act as an aid to advance venereal prophylaxis in this state. The committee has been unable to report a long list of practical results. It has sent out 800 pamphlets to physicians only, to be used at their discretion, entitled, "Gonorrhea or Clap," in which statistics from the leading authorities of the world were quoted showing the seriousness of these diseases from an economic point of view.

The next step step proposed by our committee is to send out pamphlets to the members of the profession in this state giving instruction in a concise form, of the hygienic and preventive measures to be followed out by patients who already have contracted venereal diseases.

These and other pamphlets will be compiled, that will enable the profession to disseminate a proper knowledge of this subject through the different channels as they deem advisable, so that in the future, prudery, false shame and prejudice will be eradicated and this subject may then be treated rationally and receive the same support from the public as does the hygienic mothods advocated against tuberculosis and other communicable diseases. The committee has communicated with members of the profession in the states of Oregon, California, Montana and Idaho, with the result that at an early date we hope there will be established like committees, to co-operate with your committee. Assistance has been rendered by the committee on the prevention of venereal diseases of the American Medical Association, such as ascertaining the laws regarding prostitution, the prevention of venereal diseases, etc., and the attitude of the state and local committees toward the social evil.

A varied correspondence has also been carried on in the endeavor to ascertain and formulate a universal form, for the registration of these diseases. This as yet, like many other points, is still in such an embryonic state that a more definite report cannot be presented. But we feel that the foundation for future work has been laid.

G. S. PETERKIN, Seattle, Chairman,
E. M. BROWN, Tacoma,
W. S. DURAND, Everett,

REPORTS OF SOCIETY MEETINGS.

KING COUNTY MEDICAL SOCIETY.

President, E. E. Heg, M. D.; Secretary, Carl Hoffman, M. D..

The first regular semi-monthly meeting of the King County Medical Society was held in the Seattle Chamber of Commerce, on the evening of November 7, President Heg being in the chair. Twenty-five members were present. L. H. Redon was elected to membership.

PROGRAM.

Symposium on Appendicitis.

Pathology. S. J. Holmes presented this subject, giving a resume of the pathology of the disease, according to the latest accepted theories.

Symptomatology. This paper was presented by J. P. Sweeney.

Diagnosis. J. B. Eagleson described the characteristic points of diagnosis, together with the points of differentiation from other abdominal conditions, all of which, however, also call for operation.

Treatment. P. W. Willis gave this paper, advocating radical measures of surgical interference when a diagnosis has been made.

C. B. Ford explained the order of symptoms as being colic, vomiting, tenderness that soon becomes localized, temperature. He discussed the matter of drainage, giving arguments for and against. He believed the appendix should always be removed when the abdomen is opened for other causes.

J. E. Harris opposed the use of cathartics, lest they spread the infection. Does not remove the appendix in case of abscess but by later operation.

W. T. Miles claimed that the appendix could be palpated in nearly all adbomens if pressure be made in the right location, along the outer edge of the rectus muscle.

G. W. Hawley did not believe it necessary to operate in all cases of the disease. He cited his personal experience of an attack ten years ago without subsequent return.

L. G. Lazelle opposed the use of salines, recommending enema, application of ice and absolute rest.

The subject was further discussed by all the readers of papers.

The second regular semi-monthly meeting of the King County Medical Society was held in the Seattle Chamber of Commerce, on the evening of November 21, President Heg being in the chair. Thirty-seven members and visitors were present.

An amendment to the By-Laws was passed to the effect that a member joining the Society after September 1st should be exempt from payment of dues for the remainder of that year.

PATHOLOGIC SPECIMENS.

Tubercular Lungs. J. W. Bailey presented the lungs of a patient who was sick for four days in the hospital. He had a cough but no fever. Over right lungs were signs of consolidation with exaggerated physical signs, similar signs being found over the left. Autopsy showed right lung greatly hypertrophied and encroaching on the left side. In its upper part was a large encysted cavity full of fluid, possibly an extension from the pleura. The lung was studded with tubercles. A large amount of clear fluid was in the pleural cavity. The left lung was a small, hard, leathery, fibrous mass, containing no normal lung tissue. The bronchia were distinguishable; a cavity was in the lower part.

Surgical Kidneys. J. W. Amesse displayed a pair of kidneys from a Russian sailor who performed his duties to within five days of his death. No history was obtainable bearing on the condition found, except that he had an untreated stricture of four years standing. The bladder was dilated, holding about two and one-half quarts. Both kidneys consisted of large abscess cavities, with numerous smaller ones. There was scarcely a vestige of normal kidney tissue. Both ureters were greatly dilated, to about the size of a normal aorta. They contained strictures. The doctor commented on the possibility of a man attending to work with so little kidney structure.

PAPERS.

Pain and Vomiting in Diseases of the Stomach. H. M. Read read this paper, dwelling on the significance of these two symptoms, with especial reference to acute and chronic ulcers. He called attention particularly to the pain points in this disease, situated over the epigrastic region in front and to the left of the tenth dorsal vertebra behind. He mentioned facts of differential diagnosis in the different diseases presenting these two symptoms, emphasizing that they should be considered in connection with the laboratory findings of the examinations of stomach contents. He called special attention to the distinction between this condition and cancer, mentioning the points of difference. The paper was discussed by K. Winslow, C. A. Smith, M. Russell and W. T. Miles.

Amebic Dysentery. F. S. Bourns, recently from Manila, gave a very interesting and instructive address on this subject, the result of experience and observation of several years residence in the Philippines. He gave a description of the ameba coli, its methods of culture and growth; then the pathologic change produced by it in the colon and the three types of dysentery—gangrenous, moderately severe and chronic. The sympomatology was described and the treatment given at length. The most popular and effective measure is that of colon irrigation with a solution of quinine. Solutions of acetozone and alphozone had lately been employed with success. He mentioned the chronic course of the disease, extending over many years, with frequent relapse. He stated that about 4 per cent. of the Americans in the islands have the disease and that it will probably be transported to this coast as a result of increasing trade.

H. M. Read expressed pleasure in hearing the address and commented on the importance of posting ourselves, to be able to cope with the disease if it appears among us.

Dr. Chidester, of the U. S. Army, related his experience with the disease at the Presidio hospital. There they used pure olive oil with great success, giving from 15 to 20cc. three times daily. The patients gained wonderfully in weight. The result was largely attributed to increased nourishment.

Drs. Underwood and Amesse gave their personal experiences with the disease in the Philippines, the latter characterizing it as the scourge of the tropics.

PIERCE COUNTY MEDICAL SOCIETY

President, C. Quevli, M. D.; Secretary, A. de Y. Green, M. D.

The first meeting of the Pierce County Medical Society was held

Nov. 22, 1904, in the dining room of the new Masonic Hall. It was one of the largest meetings in attendance ever held by the society.

The meeting was called to order by the president, Dr. Quevli; minutes of the last meeting were then read. After a lengthy discussion over the desirability of having the Washington State Medical Association convene in Tacoma in the fall of 1905, following the meeting of the A. M. A. in Portland, the president appointed an executive committee of arrangements, consisting or six members with himself, to attend to this affair, as follows: Drs. Quevli, E. M. Brown, Libbey, Green, Hicks, C. Balabanoff and J. R. Brown.

Dr. Yocom spoke on advantages of having a Pathologist and Bacteriologist employed by the city and county. It was resolved that: "The Pierce County Medical Society was of the unanimous opinion that an expert Pathologist and Bacteriologist should be employed by the city and county conjointly, to assist the respective Boards of Health and furnish reliable and accurate information concerning public health, which it is impossible for them to otherwise obtain." The committee appointed in charge of this consisted of Drs. T. B. Curren, F. J. Stewart, McCutcheon, Hill, Dewey, Case, R. A. Gove and McKone. At 10:15 the meeting adjourned to enjoy a very elaborate spread prepared by the entertainment committee, Drs. Hicks, Yocom and Curran.

WHATCOM COUNTY MEDICAL SOCIETY.

President, D. E. Biggs, M. D.; Secretary, W. N. Hunt, M. D.

The regular monthly meeting was held November 14, at Odd Fellows building, in Bellingham, with Dr. F. J. Van Kirk, Vice-President, in the chair.

The application of Dr. W. R. Gray for membership in the Society was presented and referred to the committee on admission and ethics.

PAPERS.

Gastralgia. This was read by Dr. L. R. Markley.

Gastric Ulcer. Was presented by Dr. A. Macrae Smith.

Both papers were interesting and instructive, the writers drawing largely upon their own experiences with these diseases. All present took part in the discussion which followed. Aljourned to meet Dec. 12th.

BOOK REVIEWS.

Edited by
Kenelm Winslow, M. D.

International Clinics. Vol. 111 Fourteenth Series, 1904. $2.00. J. B. Lippincott & Co, Phila.

The first 123 pages of the current number of this well known quarterly are devoted to syphilis. Various phases of the disease are considered in articles by high authorities, including those on Diagnosis of Chancre; on Eruptions, with numerous excellent photographic illustrations; on Fever and on Headache in syphilis; on Syphilis of the Nervous System and of the Larnyx; on Syphilitic Nephritis; Fetal Syphilis; and Syphilis and Suicide. Numerous papers on the various forms of specific treatment add to the value of the symposium. Perhaps the most interesting articles in the book, because of their account of a new addition to medical knowledge—cyto-diagnosis,—are those on Syphilitic Headache and Lumbar Puncture, and on the Diagnostic Significance and Therapeutic Application of Lumbar Puncture, the latter by Stewart of London. In these papers is shown the diagnostic value of the microscopic examination of the centrifuged sediment resulting from lumbar puncture. A polynuclear leucocytosis indicates an acute infection of the meninges, while a lymphocytosis means a meningitis of tuberculous or syphilitic origin. It is impossible to enumerate all the clinical lectures or monographs in this volume but among those of especial interest may be noted the description of the Removal of a Nail from the Bronchus with the Bronchoscope, by Lumoyez and Guisez, of Paris, and The Non-Operative Treatment of Menstrual Disorders, by Davenport, which, while possessing no novelty, has great value from the practical and common sense way in which he presents his subject. Space does not permit of a more extended notice of this standard publication which it is always a pleasure and profit to peruse.

WINSLOW.

The Surgical Treatment of Bright's Disease. George M. Edebohls, A. M., M. D., LL. D. 327 pages. Cloth. Frank F. Lisiecki, Publisher, New York.

This is an extremely interesting and carefully written work. Notwithstanding the fact that much has been done experimentally and written to show that renal decapsulation is devoid of permanent benefit in chronic nephritis, it is evident from the perusal of this very detailed and conscientious report of 72 operations for decapsulating the kidneys with 17 permanent cures, 20 cases improved and a mortality of 9.7 per cent., that the last word has not been spoken upon the subject. The oldest case of cure now dates from operation eleven and one-half years ago and the average duration of all the cures is 4 years to date. Many of the cures were accomplished in unilateral nephritis and, in some, movable kidneys were fixed in position, which fact may have some influence in the result. Eleven of the 72 cases showed a unilateral nephritis and the remaining 61, bilateral disease. In the cases of short duration, the unilateral character is more apt to be found. The diagnosis was made by macroscopic and, in some instances, microscopic examination of the kidneys when they were exposed at time of operation. The disease is classified as either chronic interstitial or chronic diffuse nephritis, and in some cases one kidney was found the subject of one and the other kidney of the other variety of disease. Prior segregation of the urine does not seem to have been practised in making a diagnosis. Edebohls lays most stress on the quantity of urea excreted in 24 hours and the necessity of always examining a 24 hour specimen. The whole work is most praiseworthy in the careful study and unremiting labor evinced by his treatise; in the wonderful character of some of his operative results, both in the remarkable temporary improvement of symptoms and in the duration of this alleviation from suffering, even to the end when death occurred; and finally in the permanent cures. The book should be read by every physician if only for a careful analytic study of such a number of cases of chronic nephritis.

WINSLOW.

Hand-Book of the Anatomy and Diseases of the Eye and Ear. For Students and Practitioners. By D B. St. John Roosa, M. D., LL. D., Professor of Diseases of the Eye and Ear in the New York Post-graduate Medical School; formerly President of the New York Academy of Medicine, Etc., and A. Edward Davis, A. M., M. D., Professor of Diseases of the Eye in the New York Post-graduate Medical School; Fellow of the New York Academy of Medicine. 300 pages. Square. 12mo. Price, Extra Cloth, $1.00, net. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

This manual is intended as a guide to undergraduates and "post-graduates" but it will be helpful to general practitioners as well. The authors do not mention all the so-called new things in opthalmology and otology—the Lord forbid. But they mention about all of them that thorough trial has proven meritorious. What they give is good and only the good is attempted. There is a sense of finality in their settlement of many moot questions that is satisfying and refreshing.

The three most noticeable features of the book are; 1st, the direct, practical nature of the information; 2nd, attention to the general health in eye and ear affections; 3d, simplicity in treatment and conservatism in operative interference. As evidence of the latter let me quote: "There is a tendency in certain quarters to perform unnecessary operations. The good of the patient should of course be the first consideration. After years of urging a rather reluctant profession to undertake operations upon the tympani and upon the mastoids, the senior author of this little volume has seen a day arrive when operations are sometimes undertaken when they are not required and are harmful." Roosa is sixty-six years of age; and this book is his final word in things opthalmologic.

STILLSON.

Blood Pressure, as Affecting Heart, Brain, Kidneys and General Circulation. A practical consideration of Theory and Practice. By Louis F. Bishop, A. M., M. D., Physician to Lincoln Hospital and French Hospital, New York. 12mo, Cloth, $1.00. E. B. Treat & Co, Publishers, New York.

This little brochure of 112 pages is devoted to a discussion of the philosophy of blood pressure, more especially emphasizing the clinical relations of blood pressure in the light of a large clinical experience.

The author purposely avoids describing the method of determining blood pressure by the sphygmo-manometer, leaving its description to other authors. He says "The tactile estimation of relative plood pressure as determined by the experienced touch, and checked by clinical symptoms, is usually correct," but he at the same time appreciates the value of the more exact innovation in the hands of competent observers. The first part of the work is given up to a brief physiologic picture of the circulation wherein the conception of the arterial system, including the heart, is that of a high-pressure receptacle for the blood, the capillaries being the ducts. Whenever there is a demand for blood in any part, the muscular covering of the organ contracts, the arterioles which lead to the proper capillaries dilate, and the demand is supplied. Two classes of cases are considered clinically—Low Pressure and High Pressure Cases.

The causes, effects and management of these are related. The relations between disease of the kidneys, heart, blood vessels and brain and the existence of a high blood pressure are clearly discussed from a clinical standpoint. Disease of all these organs are commonly combined, as logically follows their mutual dependence, and this fact is of great importance.

The book is a very suggestive one and although not in any way comparable to some of the recent treatises on the quantitative estimation of relative blood pressure, it should be distinctly understood that it does not pretend to enter this field. Since the subject is a very complicated one, and yet is of great practical value to every physician, the lucid treatment of its principles in the present work will well repay reading and rereading several times and will stimulate the reader to make more exact estimations of blood pressure which the sphygmomanometer now makes possible. WINSLOW.

Lea's Series of Medical Epitomes. Nagel's Epitome of Nervous and Mental Diseases.. A manual for Students and Physicians. By Joseph Darwin Nagel, M. D., Consulting Physician to the French Hospital, New York. In one 12mo. volume of 276 pages, with 46 illustrations. Cloth $1.00, net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1904.

This is an excellent little work embodying the essentials of nervous and mental diseases collated from all the leading authorities on the subject. While arranged for students' use, with questions for quiz exercises at the end of each chapter, it will prove of value as a quick remembrancer to the busy practitioner to refresh his memory in the essentials and more recent treatment of the various disorders considered. It is written clearly and concisely, is very readable and singularly free from serious omissions. Altogether it is a most satisfactory book of its kind. WINSLOW.

Hare's Practical Therapeutics. A text-book of Practical Therapeutics; with especial reference to the application of remedial measures to disease and their employment upon a rational basis. By Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. With special chapters by Drs. G. E. deSchweinitz, Edward Martin and Barton C. Hirst. New (10th) edition, much enlarded, thoroughly revised and largely re-written. Octavo, 908 pages, with 113 engravings and 4 full-page colored plates. Cloth, $4.00, net; leather, $5.00, net; half morocco, $5.50, net. Lea Brothers &Co., Publishers, Philadelphia and New York, 1904.

The popularity of this work is attested by the fact that this is the tenth edition put forth in the same number of years but, to those unfamiliar with the book, a short description may not be out of place. The therapeutic side of pharmacology is that emphasized, as the title suggests.

The description of the physical properties, sources and physiological actions of drugs is necessarily abbreviated while the latter 256 pages are devoted to the treatment of the more common diseases or morbid conditions. The arrangement is very convenient for reference, both that of the drugs and diseases being according to alphabetical order. The description of feeding of the sick and remedial measures other than drugs—including acupuncture, antiseptics, antitoxins, cold, counterirritation, cupping, disinfection, enteroclysis, gavage, heat, hypodermoclysis, rest cure, mineral springs, climates, suspension, transfusion, and venesection—are among the most valuable additions to the book.

The work forms a very useful book for speedy reference when in doubt as to treatment and is more suited to the practitioner than the student, in that the treatment is syptomaticly considered to a large extent which tends to superficiality in the immature. The book is well up to date and undoubtedly fills a unique position most acceptably.

Winslow.

The Physician's Visiting List for 1905. P. Blakiston's Son & Co., 1012 Walnut Street, Philadelphia. In flexible leather with pencil, pocket, etc., for 25 patients per day or week, $1.00. This publication has been issued for 54 years and contains the calendar for 1905-1906, table of signs, incompatibility, poisoning, metric system, table for converting apothecaries weight into grams, dose table according to U. S. P., 1900, asphyxia and apnea, comparison of thermometers, a new table for computing gestation and blank leaves for visiting list, memoranda, addresses of patients and nurses, accounts asked for, wants, obstetric engagements, vacinations, records of births and deaths, cash accounts, etc. It is very nicely gotten up and will prove of greatest convenience.

The Physician's Pocket Account Book. By Dr. J. J. Taylor, is a neat, compact, easily kept and strictly legal book, carried in the pocket, always with you, showing each person's account at a glance. All entries are made but once, on the day when the services are rendered, in plain legal language, and require no posting or further attention. Published by the author, 4105 Walnut Street, Philadelphia, Pa.

The book contains Obstetric, Vaccination, and Death Records and Cash Accounts. The book is 4½x6¾ inches, containing over 224 pages. Prices, bound in Leather, $1.00. Also bound in Manilla boards with separate leather case. Price of case and two manilla books, $2.00. Subsequent manilla books to use in the case, 60 cents each: two for $1.00; three for $1.40. Also large size for desk or office use, $4.00. Address Dr. J. J. Taylor, Author and Publisher, 4105 Walnut Street, Philadelphia, Pa.

Visiting and Pocket Reference Book for 1905. The following is a comprehensive contents: Table of Signs and how to keep Visiting Accounts, Obstetrical Memoranda, Clinical Emergencies, Poisons and Antidotes, Dose Table, blank leaves for weekly visiting list, Memorandum, Nurses Addresses, Clinical, Obsterical, Birth, Death and Vaccination Records, Bills Rendered, Cash Received, Articles Loaned, Money Loaned, Miscellaneous, Calendar 1905, 128 pages, Lapel Binding, Red Edges. This very complete Call Book will be furnished by the Dios Chemical Co., of St. Louis Mo., on receipt of 10 cents for postage.

REPORT OF CONTAGIOUS DISEASES.

To the Washington Board of Health for October, 1904.

	Smallpox		Scarlet Fever		Diphtheria		Typhoid Fever	
Counties.	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*	*Cases*	*Deaths*
Adams	0	0	0	0	0	0	7	0
Chehalis	0	0	0	0	4	0	0	0
Columbia	0	0	0	0	0	0	4	1
Cowlitz	0	0	1	0	12	2	3	1
Douglas	0	0	0	0	1	0	0	0
Garfield	0	0	0	0	0	0	37	4
King	0	0	2	0	2	0	5	0
Kitsap	0	0	1	0	10	2	2	1
Klickitat	0	0	0	0	0	0	4	0
Lewis	0	0	0	0	1	0	10	0
Lincoln	0	0	0	0	0	0	60	1
Okanogan	0	0	0	0	0	0	2	0
Pacific	0	0	3	0	2	0	1	0
Pierce	0	0	0	0	2	0	1	0
Skagit	0	0	0	0	0	0	7	1
Spokane	0	0	7	0	1	0	2	0
Thurston	0	0	0	0	6	1	1	0
Walla Walla	0	0	0	0	0	0	19	2
Whatcom	0	0	0	0	0	0	1	0
Whitman	0	0	2	0	0	0	21	0
Yakima	0	0	0	0	4	1	65	3
Bellingham (City)	0	0	0	0	0	0	3	0
Seattle (City)	0	0	12	0	23	4	34	4
Spokane (City)	0	0	10	0	27	0	15	5
Tacoma (City)	0	0	23	0	14	0	21	1
Total	1	0	61	0	109	10	325	24
Total, Oct., 1903	42	0	103	1	49	9	247	13
Total, 1904	282	9	920	36	969	125	995	120
Total same period 1903	831		851		242		447	

Garfield county, in October reported 25 cases of typhoid fever and 2 deaths too late to be included in the October report so they are included in this report.

ELMER E. HEG, Secretary.

NORTHWEST MEDICINE

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